General Information Form

Today's Date: ____________________

Identifying Information	
Child's Full Name:	
Date of Birth:	Age:
Home Address:	
Person completing the form:	

Parent Information			
Parent's Name	Cell Phone	Occupation	Email

Patient Medical information
Referred by:
Diagnosis:
Reason for seeking speech services:
Allergies:

Emergency Contact Information		
Emergency Contact	Phone Number	Email

Family History		
Parents	Age	Speech, language or learning related difficulties
Siblings Names	Age	Speech, language or learning related difficulties
Other people living in the home:		
Language spoken in the home (other than English):		

Prenatal History		
Pregnancy # of weeks:	Normal/Problem, if so please describe:	
Medication take during Pregnancy:		
Other pregnancies:	How many?	If problems, please describe:

Obstetrical History				
Birth Weight:	Labor: Normal or Induced?		Length of Labor:	
Any drugs or Anesthetics? If so, which?				
Please check if applies:	Caesarian ☐	Premature ☐	Breech ☐	Child rotation ☐
Special care:	Oxygen, if so, how long?		Incubation, if so, how long?	
Hospital Stay:	Child # of days:	Mother # of days:		

Medical History		
Pediatrician:	Phone number:	
Address:		
Date of last physical exam:		
Date of last hearing screening:	Results:	
Did your child have tube in their ears?	Date inserted:	Date removed:
Date of last vision screening:	Does your child wear glasses?	
Current medication (including name, dose, and reason):		

Motor Development		
Age milestone met	Developmental milestone	Please check any if appropriate:
	Sit up	☐ Trips easily ☐ No fear ☐ Runs into things ☐ Trouble with stairs ☐ Afraid of climbing ☐ Clumsy with hands ☐ Climbs poorly
	Crawl	
	Jump (with 2 feet)	
	Go up stairs walking	
	Gain bladder and bowl control	
Please describe any other motor concerns:		

Feeding Development
Do you have any concerns regarding your child's feeding and eating skills? If so, please explain.

Speech and Language Development	
Developmental milestone	Age milestone met
Coo	
Babble (da-da-da)	
Jargon (da-bee-boo)	
First word and what it was?	
Combine words ("want juice")	
What percentage of the time is your child's speech understandable to your family? ____________ What percentage of time to other people? __________	
Was there ever a time when your child's speech and language skills regressed or stopped? If so, please explain.	

Current Speech and Language Skills:
What concerns do you have about your child's speech and language skills at this time?
How do these issues impact your child at home, school and with their peers?
Has your child's speech and language been evaluated before? If so, when and where?

Educational Development		
Schools attended (including preschool)	Grades	Dates
Is your child receiving speech services at their current school? If so, please explain what services they are receiving.		

Information Release Form

Child's Name: ____

I hereby give permission to Children's Innovative Therapy Group, LLC to discuss, release, or obtain information relative to my child's therapy from the following professionals:

Name	Title	Phone number and/or email
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

______________________________ ______________________________
Parent/Guardian Signature Relationship to the Child

Policies and Procedures

December 4, 2023

Children's Innovative Therapy Group (CITG) is pleased to have you as a valued family in this practice. This practice offers a full-range of Speech-Language Therapy Services as well as any support services you might need for your child.

In order to keep these services operating at an optimal level, as of December 4, 2023 ,the Policies and Procedures are:

1. The attached Fee Schedule details billing amounts for comprehensive speech-language evaluations and individual and group therapy sessions both in the CITG office and outside of the office. A completed intake packet is required prior to the start of therapy services.

2. An invoice will be available in your Central Reach portal account on the last day of each month. Payment in full is to be made at that time by credit card or check (We accept all major credit cards). You may opt to have the charges automatically charged to your credit card at in the middle of the following month by completing a Credit Card Authorization Form or pay on your own via your Central Reach account. Please make a prompt payment when you receive your invoice to avoid any late fees. Some medical insurance policies will cover our services. You will need to submit a copy of the itemized invoice to your insurance carrier. **Regardless of the status of these insurance claims, full payment to CITG is expected upon receipt of the invoice at the end of the month**. If the insurance company should issue a check to CITG, it will be promptly endorsed and sent directly to you. CITG reserves the right to discontinue therapy services if payment is not received according to our payment policy. Therapy can also be discontinued if there is any violation of the CITG policies and procedures.

3. There is a 24-hour cancellation policy. If less notice is given, regardless of the unexpected circumstance, the full hourly fee will be charged. Please remember that once a therapy schedule has been set, that time is reserved for your child. Our therapists are paid hourly for their time. If they do not have enough time to fill a late canceled session ,they do not get paid for this time. **Therefore, a cancellation made less than 24 hours in advance is billed at the full hourly fee**. If you need to cancel, please do so in advance either in person, email your speech-language pathologist directly or at 301-913-9009 within 24 hours notice of your appointment time.

4. Our sick policy is designed to keep your child and therapist's health in mind. It is not beneficial for your child to participate in therapy while they are ill or contagious. For these purposes, your child must be fever-free and vomit-free for 24 hours. If your child has a contagious illness (such a strep throat, pink eye, green discharge from nose/eyes, chicken pox, lice, etc.) your child should be under the treatment of a physician when necessary and be receiving appropriate care for at least 24 hours prior to the session. Again, all cancellations made less than 24 hours in advance are billed at the full hourly fee since your therapist reserved this time for your child. If your child has had an illness for 4-7 days and is no longer contagious but has residual side effects such as runny nose or cough, please use your best judgment. So that we do not spread any illnesses, the practice we will provide hand sanitizer and encourage hand washing prior to the sessions. If your therapist happens to be ill, they will notify you as soon as possible and will try to reschedule that session.

Name: ____

I have reviewed the Notice of Private Practice under the Health Insurance Portability and Accountability Act (HIPAA) and have accepted the privacy practices, legal duties, and rights concerning my health information. I also understand that the information supplied is required by applicable federal and state law to maintain the privacy of my health information.

________________________________ ________________________

Parent/Guardian Signature Date

____

Printed Name of Parent/Guardian

I understand the CITG cancellation and payment policy. I understand that a cancellation made less than 24 hours in advance is billed at the full hourly fee. I also understand that payment for therapy services is due immediately upon receipt of the monthly invoice.

________________________________ ________________________

Parent/Guardian Signature Date

____

Printed Name of Parent/Guardian

Credit Card Authorization Form

Please use the following credit card to process payment.

Child's Name: ____

Credit Card Number: ____
(We accept Visa, MasterCard, American Express, Discover and Diners Club.)

Expiration Date: _________/_________
Month Year

Name on the Card: ____

Email address for the receipt: _____________________________________

This credit card is:

☐ to use THIS TIME ONLY.

☐ to KEEP ON FILE for future monthly charges going forward.

Signature: ____

Notes:

** Please note, credit cards will be charged by the second week of the **following month** of therapy (e.g. Total January therapy services charged on or before February 15th).*

4833 Rugby Avenue, Suite 500 ● Bethesda, Maryland 20814 ● 301-913-9009

Fee Schedule for Children's Innovative Therapy Group

Individual Speech-Language Therapy Sessions
Sessions at the CITG office with 1 therapist and 1 child
$150.00 per hour

Sessions outside of the office will be billed at the above specified hourly fee. Additional charges for travel time to and from the site will be billed at the same hourly fee.

Group Speech-Language Therapy Sessions
Sessions at the CITG office with 1 therapist and 2 or more children
$115.00 per hour per child in the group

Co-treatment sessions with an occupational therapist
$115.00 per hour

Evaluations and Written Reports
$150.00 per hour for evaluation testing
$150.00 per hour for a written report if requested by parents (not to exceed 2 hours)

Comprehensive Speech and Language Evaluation
$850 for 4 hours of testing and written report (2 hours)

Insurance Documentation and Communication
If communication with the insurance company requires more than 15 minutes the service will be billed as follows:

16-30 minutes: $75.00
31-45 minutes: $112.50
46-60 minutes: $150.00

Effective 3/1/2024