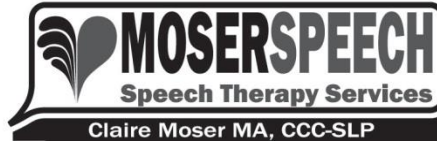


Phone: 865-579-2293  
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Suite #22  
Seymour, TN 37865

## PEDIATRIC FEEDING INTAKE – CONTACT INFORMATION

(PLEASE FILL IN ALL BLANKS TO THE BEST OF YOUR KNOWLEDGE.)

PATIENT'S NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ GENDER: \_\_\_\_\_

NATURE OF PARENT CONCERN: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CONTACT INFORMATION

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
EMAIL: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_

### PARENT/GUARDIAN'S CONTACT INFORMATION

MOTHER'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
ADDRESS (if different from child): \_\_\_\_\_  
\_\_\_\_\_  
EMAIL: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
ADDRESS (if different from child): \_\_\_\_\_  
\_\_\_\_\_  
EMAIL: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

NAME: \_\_\_\_\_  
RELATIONSHIP TO THE PATIENT: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

### PRIMARY CARE PHYSICIAN INFORMATION

REFERRING PHYSICIAN NAME: \_\_\_\_\_  
GROUP NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_  
FAX NUMBER: \_\_\_\_\_

### INSURANCE INFORMATION

INSURANCE COMPANY: \_\_\_\_\_  
MEMBER ID#: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_  
GROUP #: \_\_\_\_\_

# PEDIATRIC INTAKE – HISTORY INFORMATION

(PLEASE FILL IN ALL BLANKS TO THE BEST OF YOUR KNOWLEDGE.)

## BIRTH HISTORY

FULL TERM PREGNANCY                       UNCOMPLICATED                       C-SECTION

BIRTH WEIGHT:  pounds,  ounces

Was there anything unusual about the pregnancy or birth?     YES                       NO

If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How old was the mother when the child was born?                       How many months was the pregnancy?

Was the mother sick during the pregnancy?                       YES                       NO

If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_

Did the child go home with his/her mother from the hospital?     YES                       NO

If child stayed at the hospital, please describe why and how long. \_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY

Has your child had any of the following?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> adenoidectomy           | <input type="checkbox"/> encephalitis  | <input type="checkbox"/> seizures                   |
| <input type="checkbox"/> allergies               | <input type="checkbox"/> flu           | <input type="checkbox"/> sinusitis                  |
| <input type="checkbox"/> breathing difficulties  | <input type="checkbox"/> head injury   | <input type="checkbox"/> sleeping difficulties      |
| <input type="checkbox"/> chicken pox             | <input type="checkbox"/> high fevers   | <input type="checkbox"/> thumb/finger sucking habit |
| <input type="checkbox"/> colds                   | <input type="checkbox"/> measles       | <input type="checkbox"/> tonsillectomy              |
| <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> meningitis    | <input type="checkbox"/> tonsillitis                |
| <input type="checkbox"/> ear tubes               | <input type="checkbox"/> mumps         | <input type="checkbox"/> vision problems            |
| <input type="checkbox"/> hearing problems        | <input type="checkbox"/> scarlet fever | <input type="checkbox"/> feeding problems           |
| <input type="checkbox"/> Other: _____            |  |   |

Has your child had any serious injuries or surgeries?                       YES                       NO

If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child currently (or recently) under a physician's care?     YES                       NO

If yes, why, and who is the physician? \_\_\_\_\_  
\_\_\_\_\_

Please list any medications your child takes regularly: \_\_\_\_\_

Please list any known allergies: \_\_\_\_\_

## DEVELOPMENTAL HISTORY

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone	_____ grasped crayon/pencil
_____ babbled	_____ said first words
_____ put two words together	_____ spoke in short sentences
_____ walked	_____ toilet trained

Does your child... (Check all that apply)

choke on foods or liquids?       currently put toys/objects in his/her mouth?       brush his/her teeth and/or allow brushing?

## SPEECH-LANGUAGE-HEARING

Does your child... (Check all that apply)

<input type="checkbox"/> repeat sounds, words or phrases over and over?	<input type="checkbox"/> understand what you are saying?
<input type="checkbox"/> retrieve/point to common objects upon request (ball, cup, shoe)?	<input type="checkbox"/> respond correctly to yes/no questions?
<input type="checkbox"/> follow simple directions ("Shut the door" or "Get your shoes")?	<input type="checkbox"/> become frustrated by speech/language difficulties
<input type="checkbox"/> respond correctly to who/what/where/when/why questions?	

Your child currently communicates using... (Check all that apply)

<input type="checkbox"/> body language.	<input type="checkbox"/> sounds (vowels, grunting).
<input type="checkbox"/> words (shoe, doggy, up).	<input type="checkbox"/> 2 to 4 word sentences.
<input type="checkbox"/> sentences longer than four words	<input type="checkbox"/> other: _____

Did siblings have any speech and/or language delay? \_\_\_\_\_

What do you see as your child's most difficult communication problem at home? \_\_\_\_\_

## BEHAVIORAL CHARACTERISTICS (Check all that apply)

<input type="checkbox"/> cooperative	<input type="checkbox"/> restless
<input type="checkbox"/> attentive	<input type="checkbox"/> poor eye contact
<input type="checkbox"/> willing to try new activities	<input type="checkbox"/> easily distracted/short attention
<input type="checkbox"/> plays alone for reasonable length of time	<input type="checkbox"/> destructive/aggressive
<input type="checkbox"/> separation difficulties	<input type="checkbox"/> withdrawn
<input type="checkbox"/> easily frustrated/impulsive	<input type="checkbox"/> inappropriate behavior
<input type="checkbox"/> stubborn	<input type="checkbox"/> self-abusive behavior

## SCHOOL HISTORY (If your child is in school, please answer the following):

NAME OF SCHOOL \_\_\_\_\_ GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_

What are your child's strengths and/or best subjects? \_\_\_\_\_

Is your child having difficulty in any subjects or skills? \_\_\_\_\_

Is your receiving help in any subjects? \_\_\_\_\_

\*\*\* Is there a current IEP in place? \_\_\_\_\_

## THERAPEUTIC HISTORY

Has your child ever received an evaluation or therapy before? (Check all that apply):

<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Hearing	<input type="checkbox"/> Vision	<input type="checkbox"/> Other

### Feeding/Eating History Form

Patient Name:	DOB:	Today's Date:
Name of person completing form:	Relationship to Patient:	

**Instructions: Place a check beside any area that applies to your child**

<p><b>What is the purpose of the evaluation:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Does not like putting things in or near mouth</li> <li><input type="checkbox"/> Refusing food</li> <li><input type="checkbox"/> Difficulty transitioning to solids</li> <li><input type="checkbox"/> Choking and/or coughing when eating</li> <li><input type="checkbox"/> Gagging or vomiting when eating</li> <li><input type="checkbox"/> Difficulty accepting liquids by mouth</li> <li><input type="checkbox"/> Difficulty accepting solids by mouth</li> <li><input type="checkbox"/> Reduced variety of foods</li> <li><input type="checkbox"/> Reduced volume of foods</li> <li><input type="checkbox"/> Follow up to a swallow study (MBS or FEES)</li> <li><input type="checkbox"/> Nutrition concerns</li> <li><input type="checkbox"/> Poor weight gain</li> <li><input type="checkbox"/> Failure to thrive</li> <li><input type="checkbox"/> Other _____</li> </ul> <p><b>Allergies/Intolerances to any food, environmental, any other?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> None</li> <li><input type="checkbox"/> Yes, _____</li> </ul>	<p><b>Medical History related to feeding/eating:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Esophageal Reflux</li> <li><input type="checkbox"/> Nasal Reflux</li> <li><input type="checkbox"/> Upper GI Testing Done –results _____</li> <li><input type="checkbox"/> Modified Barium Swallow Study (MBS) Date of most recent MBS ___/___/___ Results _____</li> <li><input type="checkbox"/> Fiberoptic Endoscopic Evaluation of Swallowing, (FEES) Date of most recent FEES ___/___/___ Results _____</li> <li><input type="checkbox"/> Constipation _____</li> <li><input type="checkbox"/> Diarrhea/Loose Stools _____</li> <li><input type="checkbox"/> Asthma _____</li> <li><input type="checkbox"/> Respiratory Status: _____</li> <li><input type="checkbox"/> Cardiac Status: _____</li> <li><input type="checkbox"/> See additional history _____</li> <li><input type="checkbox"/> Related/Previous therapy services _____</li> </ul>
--	--

<p><b>IN THE PAST</b></p> <p><b>How has your child taken food in the PAST?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> By mouth</li> <li><input type="checkbox"/> By mouth and tube (NG, NJ, GJ, GT, OG, OJ),</li> <li><input type="checkbox"/> By tube (NG, NJ, GJ, GT, OG, OJ),</li> <li><input type="checkbox"/> Other _____</li> </ul> <p><b>Has your child had any feeding difficulties in the PAST?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Difficulties with Breast feeding?</li> <li><input type="checkbox"/> With transitions to foods?</li> <li><input type="checkbox"/> Controlling liquids in the mouth?</li> <li><input type="checkbox"/> Managing or accepting solids?</li> <li><input type="checkbox"/> <b>Family History of feeding problems, intolerances or allergies:</b> Please list: _____</li> </ul> <p><b>CURRENTLY</b></p> <p><b>How does your child take in food NOW?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> By mouth</li> <li><input type="checkbox"/> By mouth and tube (NG, NJ, GJ, GT, OG, OJ),</li> <li><input type="checkbox"/> By tube (NG, NJ, GJ, GT, OG, OJ),</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Is your child having any difficulties with the following?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Difficulties with Breast feeding? <input type="checkbox"/> With transitions to foods?</li> <li><input type="checkbox"/> Controlling liquids in the mouth?</li> <li><input type="checkbox"/> Managing or accepting solids?</li> </ul> <p><b>When is your child fed/ or eat by MOUTH?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ad lib</li> <li><input type="checkbox"/> _____ times a day</li> <li><input type="checkbox"/> Every _____ hours</li> <li><input type="checkbox"/> Other _____</li> </ul> <p>How long does it take to eat a meal? _____</p> <p><b>When is your child fed by TUBE:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ad lib</li> <li><input type="checkbox"/> Continuous (rate _____ for how long _____)</li> <li><input type="checkbox"/> Bolus (every ___ hours, volume _____, Frequency _____, Length of Feeding _____, Pump or syringe (gravity)</li> <li><input type="checkbox"/> Other _____</li> </ul> <p>How long does it take to deliver each feeding? _____</p>
--	--

PATIENT NAME:	DOB:	Today's Date:
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**Current diet:**

**Liquids**

- Formula (type) \_\_\_\_\_  Breast milk  Cow's milk
- Soy Milk
- Other liquids \_\_\_\_\_
- Quantity of liquid per day \_\_\_\_\_ ounces

**Solids:** Types/quantities of food eaten for meals: Not developmentally appropriate.

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snacks: \_\_\_\_\_

Dinner: \_\_\_\_\_

Other foods your child has tried 1-2 times before but does not regularly eat: \_\_\_\_\_

**Eating Routine:**

- Does your child eat in a High Chair?
- Does your child eat in a Car Seat?
- Does your child eat at the Table?
- Does your child eat at the counter/bar?
- Does your child eat with other family members present?
- Do you use distraction? List types \_\_\_\_\_

**Reported Self Feeding Skills:**

- Bottle (6+ months)
- Fingers (14-16 months)
- Spoon( 14-30 months)
- Fork (14-36 months)
- Sippy Cup
- Open Cup
- Straw
- Other** \_\_\_\_\_

**Comments:**

FAMILY HISTORY OF ALLERGIES:

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CHILD'S ALLERGIES:

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EATING CONCERN'S:

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Please list the foods your child **will eat** from each category:

Meats/Eggs/Cheese	Carbohydrates: Cereal/bread/cookies/cracker Chips/rice/potatoes	Fruits	Vegetables

Please list the foods your child **AVOIDS** from each category:

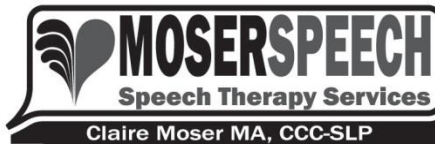
Meats/Eggs/Cheese	Carbohydrates: Cereal/bread/cookies/cracker Chips/rice/potatoes	Fruits	Vegetables

High Allergy Foods Y/N	Avoided Textures:	Snacks:	Foods you DO NOT want your child to have:
Honey            Y   N			
Peanut Butter   Y   N			
Tree Nuts        Y   N			
Citrus Fruits    Y   N			
Acidic Foods    Y   N			
Corn              Y   N			
Eggs              Y   N			
Whole Milk      Y   N			
Wheat            Y   N			
Hot Dogs        Y   N			

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## NOTICE OF PRIVACY PRACTICES

**Moser Speech Therapy Services provides this Consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

This summary of and consent for the privacy practices and patient care at Moser Speech Therapy Services and services as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent upon request. The terms of our Notice may change and you may obtain a revised copy by contacting our office.

If you ever believe your privacy rights have been violated, you may file a complaint with the Compliance Officer of Moser Speech Therapy Services or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**How will we use or disclose your information? Here are a few examples:**

- \* For speech, language & feeding treatment and referral
- \* To obtain payment and file insurance
- \* In emergency situations
- \* For appointment and patient recall reminders
- \* To run our Practice more efficiently and ensure all our patients receive quality care
- \* For research and education
- \* Prevent serious threats to health safety
- \* For workers' compensation programs
- \* In response to certain requests arising out of lawsuits or other disputes

**You have certain rights regarding the information we maintain about you. These rights include:**

- \* The right to inspect and copy
- \* The right to amend
- \* The right to an accounting of disclosures
- \* The right to request restrictions
- \* The right to a paper copy of this notice
- \* The right to request confidential communications

**By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.** You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Moser Speech Therapy Services may condition treatment upon the execution of this Consent. *This information and Notice of Privacy Practices is made available on request.*

**PATIENT NAME:** \_\_\_\_\_

**SOCIAL SECURITY:** \_\_\_\_\_

**Signed by:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Relationship (if other than patient):** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

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## CONSENT FORM

As a service to our patients, we routinely phone you the day before your appointment as a reminder to you. It may also be necessary for the secretary or Speech Therapist to contact you regarding you or your child's progress.

Confidentiality regulations require that we obtain your written consent to be contacted. Please indicate your preferences below:

- |   |     |    |
|---|-----|----|
| 1. YOU MAY LEAVE A MESSAGE ON MY ANSWERING MACHINE. | YES | NO |
| 2. YOU MAY LEAVE A MESSAGE WITH A FAMILY MEMBER.    | YES | NO |
| 3. YOU MAY TEXT WITH APPT CHANGES/REMINDERS         | YES | NO |

Is there anyone that we MAY NOT leave any information with? YES NO

If yes, please list the name(s), phone number and relationship to the patient. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Will there be anyone else bringing your child to the facility? YES NO

If yes, please list the name(s), phone number and relationship to the patient. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

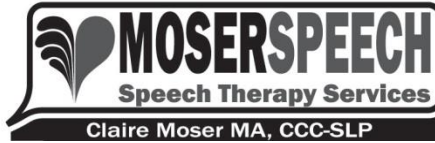
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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## ASSIGNMENT OF BENEFITS

I hereby authorize and assign payment directly to Moser Speech Therapy Services all insurance benefits due and otherwise payable to me for services provided by Moser Speech Therapy Services. I further authorize and direct my insurance company to provide Moser Speech Therapy Services with all information regarding my benefits, status of claims, reason or reasons for non-payment and any other information deemed necessary or appropriate. I hereby appoint Moser Speech Therapy Services and its authorized agents and representatives as my attorney-in-fact for the purpose of executing all claims, authorizations, and instructions relating to payment for services provided by Moser Speech Therapy Services.

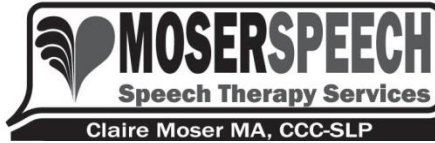
\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
INSURED/RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

Phone: 865-579-2293  
Fax: 865-579-2295

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## **PATIENT CANCELLATION / NO-SHOW POLICY**

We understand that sometimes things will come up that will prevent a patient from keeping his/her speech therapy appointment. Due to a limited amount of available appointment slots, patients are requested to cancel or reschedule appointments at least eight hours in advance when possible. Failure to cancel or reschedule appointments will result in a No-Call-No-Show fee that will be billed to your insurance company, and may affect your benefits and eligibility. This means you could lose all of your benefits and be dropped from your insurance provider.

I have read and understand the above policy.

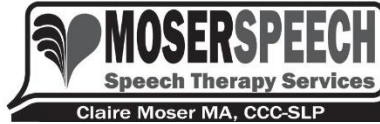
\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
PARENT SIGNATURE

\_\_\_\_\_  
DATE

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## ROUTINE VERBAL SESSION PROGRESS DISCUSSIONS

The clinical and administrative teams at Moser Speech value our relationship with the families we serve. Much of that relationship is reinforced by regular communication about your child's progress and needs. As our time with each patient is typically limited to thirty minutes, we strive to make the most of this time by providing skilled therapy in the therapy room, followed by informative routine verbal progress reports with the parent in the lobby.

**Given your signed authorization below, the clinician will share session-specific information with you verbally in the lobby at the close of each session. These discussions will be routine in nature.** (example: a report of how the session went, what they worked on, what to try at home, etc.)

**In the case of more sensitive issues, such as diagnosis, medical or behavioral concerns or any other personal subject, the clinician will not address these in the lobby. Depending on the available time, the clinician may invite you into the therapy room or another private conference area, or schedule an appointment time for a more formal conference.**

At Moser Speech, we recognize that not everyone will feel comfortable with ANY discussion in a public setting, which is why we would like for you to share with us your preference regarding the session-specific routine verbal progress discussions. We will accommodate each family's discussion preference as listed below:

**REGARDING PATIENT, \_\_\_\_\_**  
(PRINT PATIENT NAME)

\_\_\_\_\_ I authorize the staff at Moser Speech to provide session-specific routine progress reports verbally in the lobby after each session, with the understanding that these discussions will be kept general in nature and will be communicated at a reasonably low volume and will not include sensitive topics such as diagnosis, medical or behavioral concerns, or any other personal subject matter.

\_\_\_\_\_ I prefer that all discussions regarding my child's progress, including general verbal progress reports take place either in the therapy room or in a private conference setting. Please do not discuss anything about the session in the lobby or any public space.

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date Signed

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**PHOTO RELEASE / PERMISSION STATEMENT**

**PATIENT NAME:** \_\_\_\_\_

**BIRTHDATE:** \_\_\_\_\_

\_\_\_ I GIVE MY PERMISSION FOR THIS PATIENT TO BE PHOTOGRAPHED AND FOR THE PHOTOGRAPH(S) TO BE USED IN INFORMATION BROCHURES AND PRINTED LITERATURE FOR **MOSER SPEECH THERAPY SERVICES**.

\_\_\_ I GIVE MY PERMISSION FOR THIS PATIENT TO BE PHOTOGRAPHED AND FOR THE PHOTOGRAPH(S) TO BE USED ONLINE ON THE WEBSITE(S) AND SOCIAL MEDIA PAGES FOR **MOSER SPEECH THERAPY SERVICES**.

\_\_\_ I GIVE MY PERMISSION FOR THIS PATIENT TO BE PHOTOGRAPHED AND FOR THE PHOTOGRAPH(S) TO BE USED FOR EDUCATIONAL PURPOSES SUCH AS SEMINAR PRESENTATIONS, DISPLAYS, ETC.

**NOTES and/or RESTRICTIONS TO THE ABOVE INITIALED PERMISSION STATEMENTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Staff / Witness Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date Signed

**\*\*\*\*\* THANK YOU SO MUCH FOR SUPPORTING MOSER SPEECH THERAPY SERVICES! \*\*\*\*\***

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PARENT/GUARDIAN COMMITMENT TO PATIENT'S PLAN OF CARE

PATIENT NAME: [redacted] PAN: [redacted] TODAY'S DATE: [redacted]

Based on the results of your formal evaluation at Moser Speech Therapy, your SLP has recommended that you attend therapy [redacted] / week to address the goals which have been explained to you. Consistent attendance has been shown to greatly impact the amount of progress that our patients make, and as such, we ask that you make every effort to commit to the plan of care that your SLP has established.

For the convenience of our patients and their families, Moser Speech Therapy offers a "regular recurring" schedule to all patients as they enter into a Plan of Care, based on the recommended frequency, established by the SLP. A "regular" schedule means that our facility has a recurring day and time RESERVED for a patient, which allows a family to plan ahead in order to commit to the patient's plan of care.

While Moser Speech Therapy understands that things come up from time to time, creating the need for cancellations and/or rescheduling a regular appointment, Moser Speech Therapy requests the commitment of all patients/families who accept a RESERVED SCHEDULE, to adhere to their treatment plan with a minimum of 75% attendance, recognizing that RESERVED recurring appointments are offered as part of Moser Speech Therapy's practice of MUTUAL ACCOUNTABILITY, as discussed in the CORE VALUES provided to each patient on their first visit to our clinic.

If a patient is unable to commit to a "regular" (RESERVED) schedule, our Patient Service Coordinator will be happy to provide appointments as available, on a weekly basis; however, we cannot guarantee that a set day/time will be available. This may affect the frequency of sessions that a patient will receive. Moser Speech Therapy is committed to working with patients to the extent that we are able, but it is anticipated that patients will work with us to ensure that the patient is being brought regularly to the clinic.

As RESERVED appointments are limited, Patients who do commit to a "regular" (RESERVED) schedule must maintain a minimum of 75% attendance. If monthly attendance falls below 75%, their "reservation" (regular recurring appointment day/time slot) may be forfeited, at which time that patient will need to begin scheduling individual appointments on a weekly basis.

Thank you for your understanding of Moser Speech Therapy's position on this requirement. We are so privileged to be working with you and look forward to celebrating PROGRESS with each and every one of you!!

PARENT/GUARDIAN COMMITMENT TO PATIENT'S PLAN OF CARE

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

\_\_\_ I am able to commit to a RESERVED schedule: \_\_\_\_\_

I understand that by accepting this regular recurring schedule, I must commit to a minimum of 75% compliance with this schedule, and that if my attendance falls below 75%, my appointment times may be forfeited, at which time I will need to schedule individual appointments as they are available.

\_\_\_ I am unable to commit to a RESERVED schedule at this time; however, I am committed to supporting the patient's plan of care by scheduling individual appointments at the recommended frequency.

I understand that I must contact MOSER SPEECH THERAPY at (865) 579-2293 each week to schedule these individual appointments.

\_\_\_ I am unable to commit to the frequency of sessions that has been recommended by the SLP, but I am able to commit to \_\_\_\_\_ sessions per week, and will schedule individual appointments each week.

I understand that I must contact MOSER SPEECH THERAPY at (865) 579-2293 each week to schedule these individual appointments.

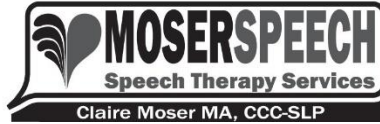
PARENT/GUARDIAN SIGNATURE

PRINTED NAME

Phone: 865-579-2293

Fax: 865-579-2295

**MoserSpeech.com**



10721 Chapman Hwy

Suite #22

Seymour, TN 37865

### **Notice of Possible Alternate SLP:**

Moser Speech is committed to providing exceptional services for you and your child. Each child will primarily see the same Speech Language Pathologist (SLP), but please know that on occasion (in cases of illness, unexpected meetings, emergencies, or vacations) your child may be seen by an assistant or a different SLP. We will always try to accommodate you and your requests. NOTE: In the event that you cancel an appointment due to your child seeing a substitute SLP, the cancellation **will** count against your attendance.

Thank you for your understanding!

Parent/Guardian Initials: \_\_\_\_\_

