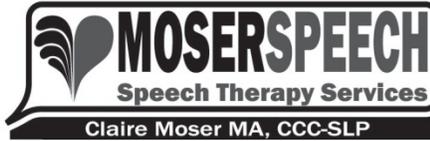


Phone: 865-579-2293
Fax: 865-579-2295

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10721 Chapman Hwy
Suite #22
Seymour, TN 37865

PEDIATRIC INTAKE – CONTACT INFORMATION

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

PATIENT'S NAME: _____ TODAY'S DATE: _____

PATIENT GOES BY: _____ BIRTHDATE: _____ SOCIAL SECURITY #: _____

GENDER: _____ RACE: _____ ETHNICITY: HISPANIC/NON-HISPANIC (CIRCLE ONE)

LANGUAGES SPOKEN IN HOME: _____

NATURE OF PARENT CONCERN: _____

WHEN CONCERN WAS FIRST NOTICED (ONSET DATE): _____

CONTACT INFORMATION

ADDRESS: _____ CELL PHONE: _____

CITY: _____ ZIPCODE: _____ EMAIL: _____

PARENT/GUARDIAN'S CONTACT INFORMATION

*PARENTS ARE: MARRIED SEPARATED DIVORCED OTHER: _____

MOTHER'S NAME: _____ BIRTHDATE: _____ SOCIAL SECURITY #: _____

ADDRESS (if different from child): _____ CELL PHONE: _____

CITY: _____ ZIPCODE: _____ WORK PHONE: _____

EMAIL: _____ EMPLOYER NAME: _____

FATHER'S NAME: _____ BIRTHDATE: _____ SOCIAL SECURITY #: _____

ADDRESS (if different from child): _____ CELL PHONE: _____

CITY: _____ ZIPCODE: _____ WORK PHONE: _____

EMAIL: _____ EMPLOYER NAME: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ PHONE NUMBER: _____

RELATIONSHIP TO THE PATIENT: _____

PRIMARY CARE PHYSICIAN (PEDIATRICIAN) INFORMATION

REFERRING PHYSICIAN NAME: _____ PHONE NUMBER: _____

GROUP NAME: _____ FAX NUMBER: _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ PHONE NUMBER: _____

MEMBER/SUBSCRIBER ID#: _____ GROUP #: _____

SUBSCRIBER NAME (IF NOT PATIENT): _____ BIRTHDATE: _____

PEDIATRIC INTAKE – HISTORY INFORMATION

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

BIRTH HISTORY

____ FULL TERM PREGNANCY ____ UNCOMPLICATED ____ C-SECTION *How many weeks was the pregnancy? _____

*CHILD'S BIRTH WEIGHT: _____ pounds, _____ ounces *NEWBORN HEARING SCREENING: _____ PASS ____ FAIL

Comments: _____

*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? _____ *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? (Please write approximate date of surgery on the line provided if applicable.)

____ adenoidectomy: _____	____ encephalitis	____ seizures
____ tonsillectomy: _____	____ allergies	____ flu
____ ear tubes: _____	____ breathing difficulties	____ head injury
____ chicken pox	____ high fevers	____ thumb/finger sucking habit
____ colds	____ measles	____ sinusitis
____ frequent ear infections	____ meningitis	____ tonsillitis
____ feeding problems	____ mumps	____ vision problems
____ hearing problems	____ scarlet fever	____ sleeping difficulties
____ Other: _____		

*Has your child had any serious injuries or surgeries? ____ YES, ____ NO If yes, please describe: _____

*When did your child suffer from his/her most recent ear infection? (date) _____

*When was your child's last hearing test? (Date of Test): _____ PASS/FAIL (circle one)

*Is your child currently (or recently) under a physician's care? ____ YES, ____ NO If yes, why, and who is the physician?

*Has your child been seen by or is followed by any medical specialist? (allergist, gastroenterologist, psychiatrist, psychologist, etc.):

*Please list any medications your child takes regularly: _____

*Please list any known Allergies: _____

*Does your child have unusual food preferences or other feeding issues? ____ YES, ____ NO If yes, please explain:

* Length of Mealtime: _____

DEVELOPMENTAL HISTORY

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

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

*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)

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

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

___ body language.	___ sounds (vowels, grunting).	___ whining/crying
___ words (shoe, doggy, up).	___ 2-to-4-word sentences.	
___ sentences longer than four words	___ other: _____	

*Who lives in the home? _____ *Sibling's Ages: _____

*Family History of speech/language delay? (If yes, please explain. E.g. uncle has stutter; brother with autism) _____

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

BEHAVIORAL CHARACTERISTICS (Check all that apply)

___ cooperative	___ restless
___ attentive	___ poor eye contact
___ willing to try new activities	___ easily distracted/short attention
___ plays alone for reasonable length of time	___ destructive/aggressive
___ separation difficulties	___ withdrawn
___ easily frustrated/impulsive	___ inappropriate behavior
___ stubborn	___ 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?** ___ YES, ___ NO *When is your next IEP meeting? _____

THERAPEUTIC HISTORY

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

___ Speech Therapy	___ Occupational Therapy	___ Physical Therapy	___ ABA Therapy
___ Hearing	___ Vision	___ Other: _____	

*How long did your child receive the above listed therapies? _____

*What areas were targeted during the above listed therapies? _____

*When and Why were these services discontinued? _____

SOCIAL HISTORY:

*Name of Daycare/Parent's Day Out Program: _____

*How often/days of the week? _____

SOCIAL/EXTRACURRICULAR ACTIVITIES (CHECK ALL THAT APPLY)

- | | |
|---|---|
| ___ Sports Leagues (Soccer, Baseball, Football, etc.) | ___ Gymnastics/ Cheer/ Dance, etc. |
| ___ Church Nursery/ Youth Group | ___ Frequent Park/ Playground Visits/ Playdates |
| ___ Library Events (Storytime/ Craft Activities) | ___ Martial Arts |
| ___ After School Program/ Boys & Girls Club | ___ Other: _____ |

WHO CARES FOR THE CHILD/DOES THE CHILD FREQUENTLY SPEND TIME WITH?

- | | | | |
|-----------------|----------------|-----------------------|---------------------|
| ___ mom | ___ aunt | ___ friend | ___ foster parents |
| ___ dad | ___ uncle | ___ sibling | ___ foster siblings |
| ___ grandmother | ___ cousin | ___ babysitter/ nanny | ___ stepsiblings |
| ___ grandfather | ___ stepfather | ___ stepmother | ___ other: _____ |

ADDITIONAL OPTIONAL INFORMATION

Moser Speech Therapy recognizes the sensitive nature of the following questions and does not require this information, but any information that you are authorized and feel comfortable to share will be held in strict confidence by Moser Speech Therapy staff and will only be used for the purpose of developing a personal plan of care for the child.

*Person filling out this form: _____ *Relationship to patient: _____

*CHILD'S TEMPERAMENT AND SENSITIVITIES (Fears, Triggers, etc. that the Speech Therapist should be aware of):

***DOES CHILD HAVE ANY DIAGNOSIS FROM ANOTHER HEALTH CARE PROVIDER THAT THE SPEECH THERAPIST SHOULD BE AWARE OF? (examples: NAS, RAD, ADD, ADHD, Anxiety, Autism, CAPD, APD):**

***WHO GAVE THE ABOVE DIAGNOSIS AND APPROXIMATELY WHEN?** _____

***IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US? (Please write on the back of this page if additional space is needed.)**

FOSTER CARE OR LEGAL GUARDIAN INFORMATION (ONLY IF APPLICABLE)

***Is Patient in Foster Care or in Legal Custody of an Individual other than Biological Parent? ____ YES ____ NO**

***Has Patient been legally adopted? ____ YES ____ NO**

***If you answered "YES" to any of the above questions, please respond to the following as you are able/willing:

INFORMATION REGARDING CHILD IN STATE, FOSTER, TEMPORARY OR PERMANENT CUSTODY.

***Patient's Current Legal Name:** _____ ***Date Of Custody:** _____

***Nickname(s), Other names that child responds to:** _____

***Legal Guardian's Name(s):** _____

***Legal Guardian's relationship to Patient:** _____

***Case Worker's Name (if applicable):** _____ ***Phone#:** _____

***CHILD HAS DIRECT OR INDIRECT CONTACT WITH BIOLOGICAL PARENT(s): ____ YES ____ NO**

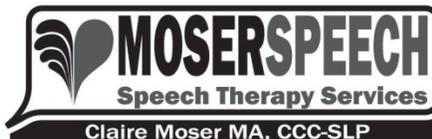
***Frequency:** _____

***IF THERE IS A PAST HISTORY OF ABUSE OR NEGLECT THAT MIGHT AFFECT CHILD'S RESPONSE TO THERAPY, PLEASE GIVE A BRIEF DESCRIPTION:**

Thank you so much for any information that helps us better approach, understand and treat this child.

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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:** _____

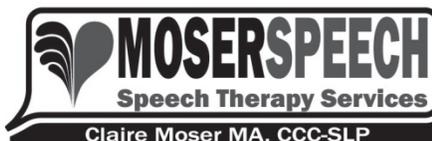
Signed by: _____ **DATE:** _____

Relationship (i.e.: mother, father, foster parent): _____

WITNESS (staff): _____ **TITLE:** _____

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

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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:

Phone number to be contacted for reminders: _____

- | | | |
|--|-----|----|
| 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. _____

Parent/Guardian Signature _____ Date _____

****Please make sure if your information changes it is updated with the office staff. Thank you!**

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

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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 CHECKED PERMISSION STATEMENTS:

_____ I DO NOT GIVE MY PERMISSION FOR THIS PATIENT TO BE PHOTOGRAPHED.

Parent/Guardian Signature: _____

Printed Name: _____ Date: _____

******* 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: _____

TODAY'S DATE: _____

Based on the results of your formal evaluation at Moser Speech Therapy, your SLP has recommended that you attend therapy [redacted] / week to address identified areas of need. 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. Patients that do not keep the minimum 75% attendance may be removed from the schedule one or all scheduled days, with the possibility of being responsible for calling the office each week at 865-579-2293 to make appointments. We cannot guarantee that a set day/time will be available when calling to make appointments.

If a patient is unable to commit to a "regular" (RESERVED) schedule, our staff 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.

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 SIGNATURE: _____

PARENT/GUARDIAN COMMITMENT TO PATIENT'S PLAN OF CARE (CHECK ONLY ONE)

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.

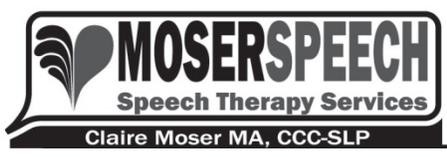
I am unable to commit to a RESERVED schedule at this time; however, I am committed to supporting the patient's plan of care by scheduling individual appointments at the recommended frequency.

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.

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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

INSUARNCE/RESPONSIBLE PARTY

PARENT/GUARDIAN NAME

DATE

PATIENT CANCELLATION / NO-SHOW POLICY

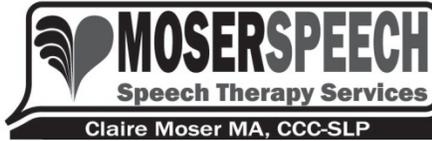
We understand that sometimes things will come up that will prevent a patient from keeping his/her speech therapy appointment. Due to a limited amount of available appointment slots, patients are requested to cancel or reschedule appointments at least eight hours in advance when possible. **Failure to cancel appointments will result in a No-Call-No-Show with a possible fee of \$30.00 each occurrence.** You may receive a text stating you were counted as a No Call No Show for that day's appointment. **If three No-Call-No-Show appointments occur you will be taken off the schedule and be responsible for calling each week to make appointments.** Patient will be discharged from services if appointments are not made within 30 days from being removed from the schedule.

I have read and understand the above policy.

PATIENT NAME

PARENT/GUARDIAN SIGNATURE

DATE



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, _____, **(CHECK ONLY ONE BELOW)**
(PRINT PATIENT NAME)

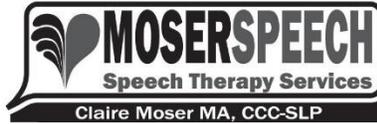
_____ **I authorize the staff at Moser Speech to provide session-specific routine progress reports verbally in the lobby after each session, with the understanding that these discussions will be kept general in nature and will be communicated at a reasonably low volume and will NOT include sensitive 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/Guardian's Signature

Printed Name of Parent/Guardian

Date Signed



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. *Additionally, graduate student clinicians may observe and treat your child under the supervision of a certified 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 Signature: _____ Date _____

Inclement Weather: Patient Policy

Here in East Tennessee, our weather is unpredictable, so before any surprises occur, we just wanted to make you aware of Moser Speech Therapy's Inclement Weather Policy.

In the event of inclement weather, **MOSER SPEECH WILL TEXT OR CALL YOU WHEN WE DECIDE TO CLOSE OR DELAY YOUR APPOINTMENT.** This text or phone call will be sent to the same phone number that you receive your appointment reminders. **Moser Speech staff or SLP may text to ask that you do teletherapy for your appointment that day via Google Meet or Zoom.** We will try to reschedule any missed appointments when possible and available.

Moser Speech Therapy's NUMBER ONE priority is the SAFETY of every patient and employee! Therefore, PLEASE DO NOT PUT YOURSELF AT RISK. If Moser Speech Therapy is open, but you do not feel comfortable driving, given the conditions in your neck of the woods, **DO NOT DRIVE.** ☺ We ask that you contact the office and inform us that you will not be in due to the weather.

IF YOU HAVE ANY QUESTIONS ABOUT THIS INCLEMENT WEATHER POLICY, PLEASE DO NOT HESITATE TO CALL THE OFFICE AT 865-579-2293.

Parent/Guardian Signature _____ Date _____

EQUAL OPPORTUNITY DISCLOSURE

The Civil Rights Act of 1964 was passed to ensure the people of the United States equal treatment, rights and opportunities regardless of race, color, or national origin. Title VI of that Act prohibits discrimination in federally funded programs.

"No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Included under National Origin is discrimination based on a person's inability to speak, read, write, or understand English. Persons whose primary language is not English can be Limited English Proficient or "LEP". These individuals may be entitled to language assistance with respect to a particular type of service, benefit, or encounter. All programs and operations of entities that receive assistance from the federal government must comply.

It is important that all applicants and recipients of services know about their rights under the law, and that employees of Moser Speech Therapy Services as well as other agencies, organizations, institutions, and contractors providing state support understand what the law requires.

Any person who applies for or receives any benefit or service provided by Moser Speech Therapy may file a complaint if he or she has had unfair or different treatment because of race, color, or national origin.

Complaints must be filed in writing with the Title VI representative of the location of the alleged discrimination i.e. Moser Speech Therapy Services; or with the appropriate regional or central office of the Department of Mental Health and Substance Abuse Services; or with the Office of Civil Rights, 101 Marietta Tower, Suite 2706, Atlanta, Georgia 30323.

Moser Speech Therapy Services does not, because of race, color, or national origin:

1. Deny an Individual any services, opportunity, or other benefit for which he/she is otherwise qualified;
2. Provide any Individual with any service, or other benefit, which is different, or is provided in a different manner from that which is provided to others under the program;
3. Subject any Individual to segregated or separate treatment in any manner related to his/her receipt of service;
4. Restrict an Individual in any way in the employment of services, facilities or any other advantages, privilege or other advantages provided to others under the program;
5. Adopt methods of administration which would limit participation by any group of recipients or subject them to discrimination;
6. Address an Individual in a manner that denotes inferiority because of race, color, or national origin.

For further information, contact Moser Speech Therapy Services Title VI Coordinator: Valerie Ward, Office Manager at 10721 Chapman Hwy, Ste 22 in Seymour, TN 37865 or call 865-579-2293.

Patient (Recipient) Printed Name

Parent/Guardian Signature

Date

Staff/Witness Printed Name

Staff/Witness Signature

Date