



Hamaguchi & Associates
Pediatric Speech-Language Pathologists, Inc.
20111 Stevens Creek Blvd., Ste. 145
Cupertino, CA 95014
(408) 366-1098 ext 3# fax (408) 366-1011
www.hamaguchiandassociates.com

Schedule Request Form for New Clients: 2019-2020 Academic Year

Child's Name: _____
Date of Birth: _____ Age: _____ Male _____ Female _____

Address _____
City/Zip _____
Home Phone _____
Best way to reach you during business hours _____

Mother's/Guardian's/Partner's Name _____
Occupation _____ Employer _____
Email: _____ Cell: _____

Father's/Guardian's/Partner's Name _____
Occupation _____ Employer _____
Email: _____ Cell: _____

Does your child have a diagnosis?
 Yes If yes, what is the diagnosis? _____
 No

Has your child (or sibling) ever received services of any kind with our practice?
 No
 Yes If so, when? _____

Who was the treating speech pathologist? _____

How did you hear about our practice? _____
If referred by a friend, please let us know who: _____

What we need from you prior to beginning therapy:

1. Fall Registration & Scheduling Forms, along with the equivalent of 2 sessions' fees. (If attending group and individual, the equivalent of one group and one individual session). You may want to consider signing up for ACH (automatic bank withdrawal) so that you don't have to come to the window for payment each time.
2. A Patient History Form
3. Copies of previous speech-language pathology reports, as well as any other pertinent reports, such as those from an occupational therapist, IEP, or psychologist. We will need to have some kind of speech evaluation or report that is no older than 11 months old, in order to begin services. Children with minor articulation difficulties can usually suffice with a screening by our staff. If you have no report and your child has anything other than a very mild, simple difficulty, we will need to perform an evaluation first.

What services are you requesting to be scheduled?

- Assessment** (skip to page 3)

- Individual or Group Therapy Services** (*Skip to page 5—we will need current reports/assessments or a recent speech IEP if we have not done the assessment at our office in order to plan the therapy program*)
- I'm not sure what my child needs.** (*Please send us all previous reports and we will give you input on this*)

Please fill out this form and return it to our office.

1. Include a short note (1-2 pages, max, please) on a separate sheet of paper, "What We Want You to Know About Our Child" including information about your child's personality, your concerns, observations and reasons for seeking an assessment and/or therapy at our office.
2. Please include a photograph of your child that we can keep in our records.
3. Fax it, drop it off, email it (frontoffice.hamaguchi@gmail.com), or mail this form, plus your letter, to our office:

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Assessment: Please read the information about our assessment process, including our fees and scheduling process prior to submitting this form. Please tell us why you would like an assessment for your child at this time (concerns, etc.) The first appointment will be with Kristen White, the director of clinical services.

I would like the following type of assessment:

- Articulation/Oral-Motor Speech Assessment - **\$299** (If no report is required - \$196; *pronunciation issues only*)
- Birth-Age 4: speech-language assessment for children - **\$750**
- Birth-Age 4: Comprehensive Assessment with Bilingual Input (Mandarin/Cantonese only) - **\$1099**
- Age 5 and up: comprehensive speech-language assessment - **\$1275** (auditory testing already done or not indicated)
- Age 6 and up: comprehensive speech-language assessment (includes auditory processing skills component) - **\$1575**
- Supplementary Testing: for children who have previous speech-language, neuropsychological or similar reports/assessments within the past 9 months and whose parents would like additional information, such as aspects of auditory processing or a more-in depth expressive language component to what was already done. Fees are prorated by time spent but do not include a written report. Reports are billed separately with our "Additional Services Form."

Individual Therapy Requests

Speech Pathologist requested:

- No preference (Our administrator will work to consider your case and match appropriately)
- Amber Antle: Monday through Thursday: first session starting 8:15am; Monday- last session for individual therapy is 3:45pm; Tuesday – last session is 4:15pm, Wednesday & Thursday- last session is 4pm.
- Kristen White: Monday, Tuesday, and Friday: first session starting at 8am and last individual session starting 2:15pm/2:30pm (groups in the afternoon each day)
- Fiona Poon: Monday thru Thursday: first session starting 8:15am, last individual session on Monday and Tuesday is 5pm; last individual session on Wednesday is 3:45pm, last individual session on Thursday is 4pm.
- Charlotte Hellmuth: Tuesday through Friday- first session starting at 8:15am; last session starting 5pm
- Sabrina Hogan: Monday through Thursday- first session starting at 8:15am; last session starting 5pm

- Emily Guenin: Tuesday through Friday-first session starting at 8:15am; last session starting 5pm
 - Amie Solomon: Mondays starting at 2:30pm and ending by 6:15pm/Fridays starting 1:30pm and ending by 5:30pm
- **Patti Hamaguchi: will only be doing assessments, mentoring, and special consults****

1. **Individual Therapy:** How many sessions per week do you wish to schedule? _____

2. **How long for each session?**

- 30 minute individual sessions (\$98)
(available before 2pm only, must schedule a minimum of 2 sessions per week)
- 45 minute individual sessions (\$147)
- One hour (\$196)

3. **Days your child is available (please check all that apply):**

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday

4. **Timeframes your child is available to START each session (please check all that apply):**

*****APPOINTMENTS AFTER 2PM HAVE A WAITLIST*****

- 8am to 10am
- 10am to 11:30am
- 1pm to 2:30pm
- 2:30pm to 4pm
- 4pm to 5pm

Please indicate any special request here: _____

Group Therapy Requests

1. **Are you interested in a social language group for your child?**

- Yes
- No

2. **Days your child is available (please check all that apply):**

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday

3. **Timeframes your child is available to START each session (please check all that apply):**

- 8am to 10am
- 10am to 11:30am
- 1pm to 2:30pm
- 2:30pm to 4pm
- 4pm to 5pm

Please indicate any special request here _____

Payment Arrangements: Payments will be due at the time of service. (Please check one below)

- Automatic Bank Withdrawals:** I am attaching a voided check for ACH withdrawal and will fill out the information required in the box below. (If you have been doing ACH withdrawal all along, we don't need a new check. Only attach a voided check if you are switching over to ACH)
- Automatic Credit Card:** We will charge your credit card for all fees.
- *I will pay by check or credit card in person when I come for my child's appointments. **Please consider automatic payments to help reduce the crowding at the front office window.*

Registration Contract: Academic Year 2019-2020
Hamaguchi & Associates Pediatric Speech-Language Pathologists, Inc.

Child's Legal First Name: _____
Parent Filling Out this Form: _____

Please leave messages on the following phone in case you need to reach our family regarding scheduling, therapist sickness, or emergencies: _____

*****Please initial to the left of each numbered item so we are assured that you have read and understood each item.*****

I am registering my child for therapy at Hamaguchi & Associates. I understand that:

_____ 1) **Attendance/Cancellation Policy:** My child is expected to attend therapy on the day/time scheduled. If I am late, I will still be billed the usual fee and the session will conclude at the scheduled time. If I do not call ahead and cancel or **give less than 3 hours' notice**, I will be charged the full fee for the session. (Fully-paid sessions are not counted towards absences.)

_____ 2) **Holiday closures:** The following dates are holidays and times the office is closed. If I celebrate a religious holiday that is not listed here, I will let the office know at the time of registration and my child will also be exempted those days as well (up to two dates, maximum, please). Please note that only the actual religious holidays are exempted if they fall on your child's therapy appointment day, *not vacation times that surround those holidays*.

- | | |
|---|--|
| • September 2 nd (Monday) | Labor Day |
| • October 31 st after 3pm is optional (Thurs) | Halloween |
| • November 28 th & 29 th (Thurs & Fri) | Thanksgiving & day after |
| • December 24 th , 25 th & 26 th (Tues, Wed, Thur) | Christmas Eve, Christmas, & day after |
| • December 31 st office closes at 12pm (Tuesday) | New Year's Eve |
| • January 1 st (Wednesday) | New Year's Day |
| • February 17 th (Monday) | President's Day |
| • April 10 th (Friday) | Good Friday |
| • May 25 th (Monday) | Memorial Day |

_____ 3) **Absences and holding your child's slot:** My child is allowed to miss up to 4 sessions per academic year if he/she comes once a week, 8 sessions if he/she comes twice a week, 12 sessions if he/she comes 3 times a week, etc. Group sessions are prorated in a similar manner, separately. The holidays listed above are not counted. **After that, I will be charged ½ the regular session fee of any session I cancel, for any reason to hold my child's slot.** I understand that insurance companies do not reimburse for cancellation fees. Due to scheduling constraints, no make-ups are allowed. *If I am starting the program after September, the number will be prorated accordingly: (After Oct. 31st: 3 sessions, after January 15th: 2 sessions, after March 30: 1 session)*

_____ 4) **Cancelling the Program:** If I choose to withdraw my child for any reason, I will fill out a "Notice to Cancel/Change Therapy Schedule" form giving 14 days' notice. (This is counted from the day it is received, not mailed.) All sessions scheduled during the 14-day period must be paid for, regardless as to whether or not my child attends them.

_____ 5) **Change of schedule:** Any change in schedule, including reducing the number of sessions per week, or changing the day or time, requires a 14-day notice via a "Notice to Change Therapy Schedule" form, which is counted from the day Hamaguchi & Associates receives written notice. Any sessions scheduled during the 14-day period must be paid for, regardless as to whether or not my child attends them.



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Sign Me Up for ACH (Attach a Voided Check)

(If you currently participate in this plan, you do not need to fill this out again)

Automatic Payment Withdrawals Directly from Your Bank

_____ **(initial)** I authorize Hamaguchi & Associates to withdraw all fees due to maintain my child's speech therapy program and account in good standing including registration fees, therapy/cancellation fees, report-writing fees, etc., per the office policies. Your account will be drafted the corresponding amount for sessions which your child(ren) attend each week. Payments are processed on the Monday following each session. A statement/receipt will be emailed with the fees detailed. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Bank Name (Depository): _____

City where bank is located: _____ State: _____

Zip code where bank is located: _____

Account Type: Checking Savings Money Market Fund

Routing number _____

Account number _____

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

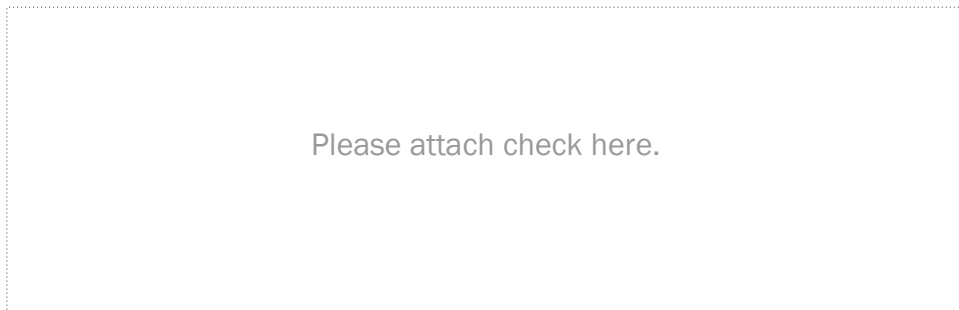
Name on Account: _____

Name(s) of children: _____

SIGNATURE _____ DATE _____

You may revoke this authorization at any time by notifying Hamaguchi & Associates in writing that you are revoking this authorization, providing adequate notice to complete in-progress transactions.

Don't forget to include a voided check.





Credit Card Recurring Payment Authorization Form

(If you currently participate in this plan, you do not need to fill this out again)

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your Visa, MasterCard, or American Express. Your card will be charged the corresponding amount for sessions which your child(ren) attend each week. Payments are processed on the Monday following each session. You agree that no prior-notification of each charge will be provided unless the date or amount changes. Only one authorization form is needed per family.

Please complete the information below:

I _____ (full name) authorize Hamaguchi and Associates to charge my credit card indicated below on a weekly basis for payment of sessions for _____ (name(s) of children) or for any other fees I direct to be charged to my card.

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: Visa MasterCard American Express

Cardholder Name _____

Account Number _____

Expiration Date _____ **CVV2/CVC Code (3 Digits on Back of Card):** _____

SIGNATURE _____

DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; provided the transactions correspond to the terms indicated in this authorization form.