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

Request Form for Teletherapy Services for New Clients: 2020-2021 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:_____

Out of an abundance of caution, we are currently providing telehealth services only, due to the nature of our profession and close contact with families. We have had tremendous positive feedback from parents about our sessions, and have been pleasantly surprised to see how well the children have adapted to this change! If you are seeking individual or group speech and language therapy sessions, please fill out the rest of this form to set up an initial consultation, along with your scheduling availability.

What we need from you prior to beginning therapy:

1. The Registration Contract, along with the equivalent of 2 sessions' fees. (If attending group and individual, the equivalent of one group and one individual session). We require a credit card on file for payments or you may sign up for ACH (automatic bank withdrawal).
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 deficit, we will need to perform an evaluation first.

What services are you requesting to be scheduled?

- ❑ **Telehealth Assessment** *(skip to page 3)*
- ❑ **Individual or Group Teletherapy 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 or 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 current teletherapy assessment process, including our fees and scheduling process prior to submitting this form.

Because we are operating virtually, we have adjusted our assessment process and fees to accommodate the limitations of standardized testing performed online. Some assessment tools lend themselves well to this format, but some do not. Therefore, our usual testing battery is being modified as a result. Until we reopen for in-person therapy, we will provide assessments as follows, in order to provide some necessary data for insurance requirements, as well as for setting goals and establishing an initial treatment plan. We can of course, modify it as always, should we find it is appropriate to do so. When possible, we will use previous assessments and IEPs to provide as much data as possible so as to minimize the need for extensive online testing.

For children ages birth-age 3: The Director of Clinical Services, Kristen White, will conduct a phone or zoom consultation with you to discuss your concerns about your child, as well as review your child's patient history and Request for Services. She will then observe your child in his or her natural environment during play with a parent. We will explain to you how to prepare for this observation. We also have a parent questionnaire we can use to obtain some standardized data and will provide you with a report of results and initial goals so we can begin therapy. If your child is able to participate, there are a few standardized tests we can do for expressive vocabulary and articulation. This is different than the usual in-person standardized testing we conduct at our clinic. However, we feel confident we can get a good picture of what to work on with this method of assessment for the time-being. Therefore, we are temporarily reducing our fee to $400 for initial assessments and a report of findings.

For children ages 4 and up: Kristen will also conduct a consultation and review of your child's patient history as described above. In addition, we are able to conduct many key tests via teletherapy if your child is able to sit in front of a screen and actively participate. We can of course have breaks and a few quick fun games to break things up. Therefore, that fee will be temporarily reduced to $700-$1,000 for an initial assessment and a summary report of findings, depending on the number of tests performed.

Articulation assessments will be $250 for an initial assessment and a summary report.

I would like the following type of assessment:

- ❑ Articulation Assessment - **$250** (If no report is required - $196; *pronunciation issues only)*
- ❑ Birth-Age 3: speech-language assessment for children - **$400**
- ❑ Age 4 and up: speech-language assessment - **$700-$1,000** (actual rate will depend on amount of testing able to be completed and the child's age)
- ❑ Ages 7 and up: Comprehensive speech-language assessment with auditory processing/auditory memory testing is **$1299**
- ❑ 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 -Thursday: first session starting 8:15am, last individual session on Monday and Tuesday is 4pm; last individual session on Wednesday is 3:15pm, last individual session on Thursday is 4:15pm.
- ❑ Fiona Poon: Monday -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 - Friday: first session starting at 8:15am; last session starting 5pm
- ❑ Nikki Calderon: Monday - Friday: 10am-6pm, last session starting at 5 pm; Fridays 8am-4pm, last session starting at 3:15pm.
- ❑ Emily Guenin: Tuesday through Friday: first session starting at 8:15am; last session starting 5pm

Kristen White: is no longer accepting new clients

Patti Hamaguchi: will only be doing mentoring and special consults

1. **Individual Teletherapy:** 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*****

- ❑ 8:15am to 10am
- ❑ 10am to 11:15am
- ❑ 1pm to 2pm
- ❑ 2pm to 3pm
- ❑ 3pm to 4pm
- ❑ 4pm to 5pm

Please indicate any special request here: _____

Group Teletherapy 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):

- ❑ 8:15am to 10am
- ❑ 10am to 11:15am
- ❑ 1pm to 2pm
- ❑ 2pm to 3pm
- ❑ 3pm 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.

Registration Contract: Academic Year 2020-2021
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. Insurance will not cover cancellation fees. (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 7th** (Monday) **Labor Day**
- **November 26th & 27th** (Thurs & Fri) **Thanksgiving & day after**
- **December 24th, 25th** (Thurs, Friday) **Christmas Eve, Christmas**
- **December 31st office closes at 12pm** (Thursday) **New Year's Eve**
- **January 1st** (Friday) **New Year's Day**
- **February 15th** (Monday) **President's Day**
- **April 2nd** (Friday) **Good Friday**
- **May 31st** (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.

_____6) **Insurance:** Insurance companies require certain reports and regular assessments. If I plan to seek reimbursement, I must let Hamaguchi & Associates know at the start of therapy and assume any added cost, as well

as providing the front office with the appropriate documentation. (Insurance card and physician's prescription). If my insurance company requires a written report, I will give Hamaguchi & Associates at least 3 weeks' notice and fill out the "Additional Services Request" form and pay the associated fee for this service.

_____7) **Receipt of Forms**: I have received and understand the following flyers: "Office Policies", "Working with the Schools", HIPAA regulations, "If you Intend to Seek Insurance", and "Agreement to Videotape".

_____8) **Parental Authority to Commit to Services:** By signing this contract, I am signifying that I have the legal authority to make decisions about this child's care. If I have a custodial agreement due to a divorce, I will have my child's other parent sign as well, even if he/she is not financially responsible for paying for the sessions.

_____9) **Attending to Teletherapy:** I understand that if my child cannot appropriately attend to a teletherapy session, and a communication helper (i.e. parent, nanny) is unavailable to help my child participate in session, then our style of therapy may not be a good fit and an alternative service will be recommended elsewhere.

_____10) **Expectation of Progress:** While most children make terrific progress, sometimes children reach a plateau, or make very limited or no progress. As a general rule, we should be able to see some documentable progress within a few months. Poor progress can be due to physiological limitations within the mouth/brain, the severity of the diagnosis, behavioral issues where the child is non-compliant during the session or with home practice, or simply not a good candidate for the kind of therapy we do. Ethically, we feel it is important for a child to show progress and improve because speech therapy is an extremely expensive and time-consuming process. If we (or you) feel that continued therapy is unlikely to yield desired progress, we will want to have a conversation about appropriate next steps, which might include taking a break from therapy (and waiting for the child to mature a little more) or trying a different kind of therapy somewhere else.

_____

(Please print the name of the parent who is financially committing to pay for this program here)

_____

* Signature of parent who is financially committing to pay for this program Date

*If divorced and sharing joint custody under court order, both parents must sign below to give us permission to provide services, regardless of who is paying for the services.

_____

Please print the name of the second parent Date

_____

Signature of second parent who grants permission for services Date

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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.

Please attach check here.

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.