



# All of Me Therapy, LLC

Date: \_\_\_\_\_

## **CHILD/FAMILY HISTORY**

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex M F Grade \_\_\_\_\_

Primary language(s) in the home \_\_\_\_\_ Child's primary language \_\_\_\_\_

Name and relationship of person completing questionnaire \_\_\_\_\_

## **REFERRAL INFORMATION**

Referred by (family, physician, clinic, other professional etc.) \_\_\_\_\_

What are your main concerns regarding your child's communication skills?

What do you hope to gain from this evaluation?

## **RESPONSIBLE PARTY**

Responsible party and relationship to child \_\_\_\_\_

Address \_\_\_\_\_

Cell Phone \_\_\_\_\_ Accept text messages? Y N Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email \_\_\_\_\_

I give consent for All of Me Therapy, LLC to communicate with me and my therapy providers through non-secured electronic correspondence (email & texting). I acknowledge and agree that information sent via email is not considered secure. Therefore, I agree that All of Me Therapy, LLC has no liability to me for any loss, claim, or damages arising or in any way related to response(s) to any email or other electronic communication.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **FAMILY INFORMATION**

Parent's marital status: Married Separated Divorced Single Deceased Other

Please list all family members who spend a significant amount of time with the child:

Name (parent's, stepparents, siblings, grandparents, etc.)	Age	Occupation	Health Concerns	Sex M/F	Lives in the home?

Any other caregivers? \_\_\_\_\_

What are the child's favorite activities and/or games?

## **DEVELOPMENTAL HISTORY**

### **Prenatal**

- Excessive vomiting       Excessive fatigue       Premature labor       Excessive weight gain       Inadequate weight gain
- Anemia       Heart problems       Rh incompatibility       High Blood Pressure
- Medications other than prenatal vitamins       Special Diet       Thyroid Disease       Diarrhea
- Diabetes       Swelling       Fever       Preeclampsia       Bleeding/spotting
- Measles       Accident       Bedrest       Premature rupture of membranes
- Exposure to smoke       Exposure to drugs       Exposure to alcohol       Exposure to domestic violence

Comments: \_\_\_\_\_

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**Labor and Delivery**

Gestational Age? \_\_\_\_\_ Vaginal Delivery C-Section Birth Weight? \_\_\_\_\_ Birth Length? \_\_\_\_\_  
 Regular Nursery NICU Length of stay? \_\_\_\_\_ Reason for extended stay? \_\_\_\_\_

Any complications during or after delivery?

**Infancy/Childhood**

Please describe in detail the first two years of the child's life. Was s/he fussy, happy, colicky, etc.? Any outstanding events? Was the child exposed to any toxins?

Any reactions to immunizations? \_\_\_\_\_  
 Breastfed Y N How long? \_\_\_\_\_ Thumb sucking or pacifier use? Y N How long? \_\_\_\_\_  
 Toilet trained? Y N Age? \_\_\_\_\_ Health concerns? Y N Explain \_\_\_\_\_

**Milestones**

My child was (check all that apply):  alert  easily comforted  colicky  aware of light/sound  difficult to comfort  lethargic  
 My child's early motor development (walking, talking, toileting, etc.) was:  early  average  late  
 Please indicate when each milestone was met:

Sat up unassisted \_\_\_\_\_ Crawled \_\_\_\_\_ First word \_\_\_\_\_  
 2-3 word phrases \_\_\_\_\_ Walked unassisted \_\_\_\_\_ Full sentences \_\_\_\_\_  
 Did the child babble and coo? \_\_\_\_\_ Was the child a quiet baby? \_\_\_\_\_

**Health**

Physician (name, address, phone number) \_\_\_\_\_ Date of last visit? \_\_\_\_\_

How would you describe the child's current general health? \_\_\_\_\_

Is there a history of any of the following?

	Yes	No	Comments
Allergies			
Asthma			
Autism/PDD			
Bronchitis			
Seizures/Epilepsy			
Ear Infections			
Gastrointestinal Problems			
Serious Injuries			
Surgeries			
Hospitalizations			
Sensory Integration Issues			
Feeding Problems			

Is the child currently taking any medications? \_\_\_\_\_ For what? \_\_\_\_\_  
 Any allergies? \_\_\_\_\_ Is the child following a particular diet? \_\_\_\_\_

**Visual Development**

Date of last eye exam? \_\_\_\_\_ Results? \_\_\_\_\_  
 Does the child wear glasses? Y N Is the child sensitive to light? Y N Does the child squint? Y N  
 Any other concerns with the child's vision?



**Auditory Development**

Date of last hearing screening? \_\_\_\_\_ Results? \_\_\_\_\_

Chronic of ear infections? \_\_\_\_\_ How many? \_\_\_\_\_ PE Tubes? \_\_\_\_\_ How long? \_\_\_\_\_

Does the child have a diagnosis of hearing loss? \_\_\_\_\_ Correction? \_\_\_\_\_

Does your child:

- Y N Hear things before you hear them?
- Y N Seem overly sensitive to sound?
- Y N Become frightened by certain sounds? What sounds? \_\_\_\_\_
- Y N Miss some sounds?
- Y N Seem confused about the direction of sounds?
- Y N Like to make loud noises?
- Y N Become easily distracted?
- Y N Tend to 'tune you out' when there is background noise present, such as a fan, dishwasher, or tv?
- Y N Need to have instructions repeated frequently?
- Y N Often say, "What?" or "Huh?"
- Y N Often fail to pay attention when being spoken to?
- Y N Often need an unusually long amount of time to process verbal information before responding?
- Y N Often have difficulty remembering what was said?
- Y N Frequently lose his/her concentration?
- Y N Have others who work with the child (i.e., teacher, therapist) commented on his/her listening skills?

**Speech and Language Development**

Is the child talking yet? Y N

Describe the child's speech and language and any problems

Does the child have difficulty pronouncing certain sounds? \_\_\_\_\_ If so, please list \_\_\_\_\_

Does the child mumble often? \_\_\_\_\_ Does the child seem inhibited by his/her speech difficulty? \_\_\_\_\_

Does the child often reduce or transpose the number of syllables in a word? (ex" "Indiana" pronounced as "danna") \_\_\_\_\_

If school age, does the child write words with the same error pattern exhibited in their speech? \_\_\_\_\_

What percentage of the child's speech can the mother understand? All Most Some Very Little

What percentage of the child's speech can other adults understand? All Most Some Very Little

**Expressive Language**

- Y N Does the child use a lot of gestures?
- Y N Does the child seem frustrated by his/her difficulty talking?
- Y N Does the child nod his/her head for yes/no questions?
- Y N Does the child repeat (echo\_ the question instead of answering it?
- Y N Does the child seem disinterested in talking?
- Y N Does the child seem overly interested in one particular thing?
- Y N Does the child seem to be exceptionally good at learning letters or reading?
- Y N Does the child seem to be exceptionally good at doing puzzles?
- Y N Does the child seem to be exceptionally good with, or interested in, computers?
- Y N Does the child seem to 'ramble on' (out of sequence) when retelling events or explaining so that it is difficult to follow?
- Y N Does the child use an inordinate amount of "uhs" and "ums" in his/her conversational speech?
- Y N Does the child use vague language frequently, so that it is difficult to follow at times?
- Y N Does the child tend to confuse positional words, such as "left/right"?
- Y N Does the child have difficulty speaking in complete sentences with normal grammar?
- Y N Does the child have a difficult time elaborating on a topic; yet can answer Y/N questions about it?
- Y N Does the child forget names of familiar things?
- Y N Does the child have trouble answering "wh" questions?



**Motor Development**

Hand Dominance: R L Age Established? \_\_\_\_\_

Does the child:

*Muscle Tone*

- Y  N Have a grasp that is less mature than peers/
- Y  N Seem weaker or stronger than normal? Explain: \_\_\_\_\_
- Y  N Have any diagnosed muscle pathology? (e.g., spasticity, flaccidity, rigidity) Explain: \_\_\_\_\_

*Coordination*

- Y  N Have difficulty manipulating small objects easily
- Y  N Seem accident prone?
- Y  N Eat in a sloppy manner?
- Y  N Have difficulty dressing and/or fastening clothes? Explain: \_\_\_\_\_
- Y  N Have a consistent hand dominance?
- Y  N Have trouble riding a tricycle and/or bicycle?
- Y  N Have trouble playing on playground equipment?

*Sensory – Tactile Sensation*

- Y  N Object to being touched/cuddled? Explain: \_\_\_\_\_
- Y  N React negatively to the feel of new clothes?
- Y  N Prefer certain textures of clothing?
- Y  N Dislike having hair and/or face washed? Explain: \_\_\_\_\_
- Y  N Dislike having teeth brushed and/or nails clipped? Explain: \_\_\_\_\_
- Y  N Avoid certain textures of food? Explain: \_\_\_\_\_
- Y  N Isolate self from other children? Explain: \_\_\_\_\_

*Sensory – Vestibular Sensation*

- Y  N Seem fearful in space (i.e., going up and down stairs)? Explain: \_\_\_\_\_
- Y  N Appear clumsy, often bumps into thing or falls down? Explain: \_\_\_\_\_
- Y  N Climbs well but is cautious of others bumping into him/her? Explain: \_\_\_\_\_
- Y  N Spins?
- Y  N Walk upstairs always leading with the same foot?

*Sensory – Olfactory*

- Y  N Explore the environment with smell? Explain: \_\_\_\_\_
- Y  N Discriminate odors poorly?
- Y  N React defensively to smell? Explain: \_\_\_\_\_

*Sensory – Gustatory Sensation*

- Y  N Acts as though all food tastes the same? Explain: \_\_\_\_\_
- Y  N Open to tasting new foods?
- Y  N Dislike foods of a certain texture or multiple textures? Explain: \_\_\_\_\_
- Y  N Avoid or crave certain temperatures of food? Explain: \_\_\_\_\_

**Oral Motor Development**

How would you describe the child's chewing and swallowing? (check all that apply)

- Typical for his/her age
- Messy for his/her age
- Chokes at times, more than I would expect
- Has a limited number of foods s/he will eat (list favorites \_\_\_\_\_)
- Avoids hard and crunchy foods
- Stuffs lots of food into his/her mouth
- Drools when at rest
- Drools when eating
- Liquids leak from nose

Are you concerned with the child's nutrition as a result of his/her feeding difficulties? Describe:



**Social Interactions and Behavior** (check all that apply)

How would you describe the child's social interactions?  Typical for age  Quiet  Outgoing

- Likes to point out things to show you
- Does not play 'pretend' or imaginary games well
- Usually doesn't acknowledge people (waving, saying 'hi') when they enter unless prompted
- Usually doesn't acknowledge people (waving, saying 'bye') when they leave unless prompted
- Is unusually active for his/her age
- Prefers playing alone
- Prefers to play with younger children
- Has a shorter attention span than would be expected for his/her age
- Avoids eye contact
- Doesn't seem to know how to interact with other children even though s/he wants to
- Is unusually irritable on noisy or crowded places such as malls, parties, etc.
- Often repeats phrases heard out of context
- Doesn't respond to his/her name consistently
- Has periodic screaming fits (beyond typical tantrums)
- Short temper
- Can be violent or unusually physically aggressive (beyond typical childhood outbursts)

Any other behavior or emotional concerns? \_\_\_\_\_

**PREVIOUS EVALUATIONS AND TREATMENT**

Is there a family history of speech, language, or learning disabilities? \_\_\_\_\_ If yes, please Explain

Has your child been diagnosed with Autism Spectrum Disorder? \_\_\_\_\_ Age at diagnosis? \_\_\_\_\_ Who diagnosed? \_\_\_\_\_

Has your child previously been diagnosed with any condition that would affect his/her speech, language, or auditory skills? (Down Syndrome, PDD, Cerebral Palsy, Hearing Impairment, etc.)

Has the child been evaluated for speech, language, or auditory problems in the past? \_\_\_\_\_ When? \_\_\_\_\_

Results? \_\_\_\_\_

Has the child been evaluated by a physical or occupational therapist in the past? \_\_\_\_\_ When? \_\_\_\_\_

Results? \_\_\_\_\_

Has the child been evaluated by a psychologist or learning specialist in the past? \_\_\_\_\_ When? \_\_\_\_\_

Results? \_\_\_\_\_

Has the child been evaluated by a neurologist in the past? \_\_\_\_\_ When? \_\_\_\_\_

Results? \_\_\_\_\_

Has the child been evaluated by an ear-nose-throat physician? \_\_\_\_\_ When? \_\_\_\_\_

Results? \_\_\_\_\_

**EDUCATIONAL HISTORY**

Did the child attend preschool? Y N Ages? \_\_\_\_\_ Where? \_\_\_\_\_

Has the child ever repeated a grade? Y N Which grade? \_\_\_\_\_

Has the child ever participated in a special education evaluation? Y N When? \_\_\_\_\_

Has the school system implemented an IEP for the child? Y N Date: \_\_\_\_\_ School? \_\_\_\_\_

**School Problems**

If the child is currently attending school, please check off each area the child is having difficulty in:

- learning the names of letters
- printing letters
- spacing words and letters on the page
- remembering the sounds the letters make
- putting letters together to sound out a word
- comprehending information that has been read
- following directions from the teacher

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- spelling
- writing spelling words in sentences
- keeping his/her attention on the teacher
- completing homework independently
- gripping the pencil without breaking the tip or his/her hand getting sore
- copying letters or words from the board to his/her paper
- copying anything from a book or paper to another paper
- forgetting assignments/books at school
- learning math facts
- understanding math word problems
- learning and remembering vocabulary for subjects such as Social Studies
- pronouncing and learning new multi-syllabic words
- remembering what people say
- putting things in order (sequencing, days of the week, months of the year, etc.)
- misunderstanding what to do on assignments or projects
- taking tests orally
- answering fill in the blank questions
- answering open ended essay questions

Additional parent observations/comments regarding academic achievement:

**BEHAVIOR/CHARACTER**

Please describe any behaviors that are a concern at home, at school, or in the community. What was the age of onset and the age you became concerned?

**List:**

Strengths	Weaknesses

**Check any behavior characteristics that apply to the child:**

<input type="checkbox"/> Aggression	<input type="checkbox"/> Low self-esteem	<input type="checkbox"/> Short attention span
<input type="checkbox"/> Unusual Fears	<input type="checkbox"/> Manipulative	<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Depression	<input type="checkbox"/> Nail biting	<input type="checkbox"/> Frequent crying
<input type="checkbox"/> Impulsive	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Truancy
<input type="checkbox"/> Noncompliant	<input type="checkbox"/> Perfectionist	<input type="checkbox"/> Moodiness
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Tics/nervous gestures	<input type="checkbox"/> Hyperactivity/Attention Deficit Disorder
<input type="checkbox"/> Poor motivation/apathy	<input type="checkbox"/> Bedwetting/toileting problems	<input type="checkbox"/> Unkempt personal appearance



# All of Me Therapy, LLC

**Please check all areas of concern:**

<input type="checkbox"/>	Attention	<input type="checkbox"/>	Focusing
<input type="checkbox"/>	Following Directions	<input type="checkbox"/>	Understanding what is being said
<input type="checkbox"/>	Behavior	<input type="checkbox"/>	Speech
<input type="checkbox"/>	Language	<input type="checkbox"/>	Tantrums
<input type="checkbox"/>	Motor Skills	<input type="checkbox"/>	Reading and Spelling
<input type="checkbox"/>	Learning	<input type="checkbox"/>	Social Skills
<input type="checkbox"/>	Transitions and Flexibility	<input type="checkbox"/>	Sleep Patterns
<input type="checkbox"/>	Food Habits	<input type="checkbox"/>	Other (describe)

**Please check all areas you would like to see improvement:**

<input type="checkbox"/>	Listening	<input type="checkbox"/>	Learning
<input type="checkbox"/>	Attention	<input type="checkbox"/>	Speaking
<input type="checkbox"/>	Behavior	<input type="checkbox"/>	Critical Thinking
<input type="checkbox"/>	Reading and Spelling	<input type="checkbox"/>	Organization
<input type="checkbox"/>	Social and Behavioral Skills	<input type="checkbox"/>	Memory
<input type="checkbox"/>	Motor Skills	<input type="checkbox"/>	Other (describe)

Describe the child's typical day:

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Describe the child's interests and activities:

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Is there any additional information that would help us better understand the child?

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**Clinic Policies and Financial Agreement**

1. Sessions will begin and end at designated times. Speech therapy services are provided in 45-minute increments and occupational therapy services are provided in 60-minute increments unless other arrangements have been made. A parent or guardian must be back on site 10 minutes prior to the end of the session. We do not have additional staff available to monitor children when the guardian is not back in time, and we must remain fair to the following client and start the next session on time. If you leave and do not return to the clinic prior to the end of your child's session the following will apply: 1<sup>st</sup> time: Reminder of policy, 2<sup>nd</sup> time: \$25 fee, 3<sup>rd</sup> time: You will no longer be able to leave the clinic during sessions or your child will be removed from the schedule. \_\_\_\_\_(initial)
2. Please make sure your child has a chance to use the restroom prior to beginning therapy. If your child wears diapers, please make sure the diaper is clean and dry prior to the beginning of the session. If you choose to leave the clinic for any reason you must leave changing supplies (diapers, wipes, and change of clothes), as we do not have these supplies on hand. If you do not leave changing supplies, we require you to remain in the clinic for the entire session in event of an accident. \_\_\_\_\_(initial)
3. Our clinic is a teaching facility, therefore, there may be times when sessions are observed, or conducted, by supervised student clinicians, SLP-A's or COTA's. \_\_\_\_\_(initial)
4. There may be times when you will not be scheduled with your usual therapist. Rest assured that all our therapists provide the same level of exceptional care. \_\_\_\_\_(initial)
5. If you must cancel an appointment, 2-hour notice must be given. All cancellations will result in a \$75 charge to your account. NO -SHOW sessions will result in a \$150 fee. Make-up sessions must be scheduled and attended within 2-weeks of the original session. Any charges will be removed once the makeup session is attended. Insurance companies will not be billed for cancelled or no-show sessions, fees will be billed directly to the family for payment prior to the next treatment session. Scheduled sessions will not be held and cannot resume until fees are paid in full. If fees are not paid in full within 10 calendar days of invoice, you will lose your scheduled time slot. \_\_\_\_\_(initial)
6. Family understands they are ultimately responsible for all charges not covered by outside resources, such as insurance. \_\_\_\_\_(initial)
7. As a courtesy, we will file insurance claims on your behalf. Cash and co-insurance payments are due at the time of service. \_\_\_\_\_(initial)
8. Insurance plans that require a referral are the responsibility of the insured and referrals must be on file with our office before treatment can begin. Families assume financial responsibility for any treatment sessions that are not authorized for insurance coverage. \_\_\_\_\_(initial)
9. We ask that families review statements issued by their insurance companies, which reflect payments made to All of Me Therapy, LLC, to ensure accuracy and to stay up to date on benefit status.
10. Brief session notes will be kept each session. Progress notes will be completed every 6-months. A complete, formalized re-evaluation of progress will be conducted annually.
11. All session notes, evaluation, and re-evaluation reports can be accessed through your online client portal. There will be a \$0.25/page charge (\$20.00 max.) for paper copies of any log notes, evaluations, or re-evaluation reports.
12. Rates are as follows:
  - a. Insurance or other outside resources: \$200/individual session, \$450/initial evaluation, \$300/annual re-evaluation, services outside of direct therapy (such as school meetings, etc.) \$100/hour. Insurance copays are due at the time of service.
  - b. Cash payments: \$105/45-minute speech session, \$136.50/60-minute occupational therapy session, \$315/initial evaluation, \$250/annual reevaluation, services outside of direct therapy (such as school meetings, etc.) \$100/hour. (Discount does not apply to insurance copays.) Cash payments are due, in full, at the time of service. Sessions will not resume until outstanding balance is paid in full.
13. An invoice will be generated at each visit when there is a balance due.

**I have read, understand, and agree to the clinic policies listed above. I understand that I am responsible for ensuring payment of services and understand that visits may be terminated, and documentation withheld until payment is received in full. I understand that visits may be terminated at any time by either party, and I agree to comply with the policies stated above.**

\_\_\_\_\_  
Patient's name (print)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date





**TELEPRACTICE INFORMED CONSENT/DECLINE FORM**

Due to the closure of our practice because of COVID-19, we adapted our service delivery model to include teletherapy services to maintain continuity of services for our families. We have reopened and are resuming face-to-face services and plan to discontinue most regularly-scheduled teletherapy by August 31, 2020. However, in the event of an emergency, extreme circumstances, or another government-mandated closure, we want to provide families with the option of teletherapy to maintain continuity of services. Please indicate your interest in receiving teletherapy if needed:

\_\_\_\_\_ YES, we would like to utilize teletherapy if needed.

\_\_\_\_\_ NO, we are not interested in teletherapy at any time.

The American Speech and Hearing Association (ASHA) defines telepractice (the act of providing telehealth services) as "the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation." This means that we are able to provide speech therapy services through digital meetings similar to the popular communication system "Skype." While we do not specifically utilize Skype for the provision of services, the method of delivery would be similar in nature. The therapist and the child would join a computer-based session at the designated therapy time and would work on the same materials as in the office. We term this "teletherapy."

I \_\_\_\_\_, the legal parent/guardian of \_\_\_\_\_ (child's name) hereby consent to engage in teletherapy with All of Me Therapy, LLC. I understand that "teletherapy" includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical information, both orally and visually.

I understand the following with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.
2. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of All of Me Therapy, LLC, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
3. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
4. Teletherapy has been determined as an appropriate service delivery model for this patient. Teletherapy will only be used if determined to be at least as effective as in-person treatment. If teletherapy is not deemed as effective, you will be notified and referred back to in-person treatment. In order to participate in teletherapy, the patient must first participate in an in-person evaluation. For certain individuals, we ask that an adult facilitator be present in the room for assisting with technical difficulties or keeping a child on task. Teletherapy will only be used for the duration of the COVID-19 crisis.
5. I have read, understand and agree to the information provided above.

\_\_\_\_\_  
Patient's name (print)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



# All of Me Therapy, LLC

## Authorization to Bill Health Insurance/Assignment of Benefits

### Primary Insurance Information

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy ID Number: \_\_\_\_\_ Group #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Please Circle: HMO PPO Other \_\_\_\_\_

### Secondary Insurance Information

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_\_

Policy ID Number: \_\_\_\_\_ Group #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Please Circle: HMO PPO Other \_\_\_\_\_

I, \_\_\_\_\_ (print name) authorize All of Me Therapy, LLC, to bill \_\_\_\_\_ (name of insurance company) for services rendered by All of Me Therapy, LLC.

I also agree to have any or payments made by said insurance company to be payable directly to:

All of Me Therapy, LLC  
1160 Joliet Street Suite 102  
Dyer, IN 46311

By signing this document, I also agree to the following statements:

- I understand that I am responsible for understanding information about my health insurance policy and providing such information to All of Me Therapy, LLC, for correct billing. I am also responsible for notifying All of Me Therapy, LLC in the case of any changes in my health insurance status.
- I understand that All of Me Therapy, LLC will be providing services, and billing my health insurance for those services, at various times during the course of my care in this office.
- I understand that ultimately, I am responsible for payment of any and all charges relating to treatment and services that I have received at All of Me Therapy, LLC during my care.
- I understand that my insurance company and any related policy/plan may offer benefits for services provided at All of Me Therapy, LLC, but that such benefits do not necessarily guarantee payment for those services, charges for services not covered by my insurance policy/plan will be my responsibility.
- I understand that the policy of All of Me Therapy, LLC requires payment in full for all services rendered at the time of visit.

I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge, and I understand that it is my responsibility to alert All of Me Therapy, LLC of any change in my medical status or insurance coverage.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# All of Me Therapy, LLC

## Consent for Electronic Communication

I, \_\_\_\_\_, do hereby give consent for All of Me Therapy, LLC to communicate with me and my therapy providers through non-secured electronic correspondence (email & texting). I acknowledge and agree that information sent via email is not considered secure. Therefore, I agree that All of Me Therapy, LLC has no liability to me for any loss, claim, or damages arising or in any way related to response(s) to any email or other electronic communication.

Parent/Guardian Name: \_\_\_\_\_ Child's Name: \_\_\_\_\_  
Child's Date of Birth: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Cell Phone Number: \_\_\_\_\_ Accept text messages? Yes No  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Photo Release

I, \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_ hereby authorize and consent to the use of his/her visual image by All of Me Therapy, LLC for appropriate purposes, including but not limited to: still photography, videotape, electronic and print publications and websites. I give this consent with no claim for payment.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

## Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of All of Me Therapy, LLC Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that All of Me Therapy, LLC reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient