SUMMER 2018

SAY & PLAY

Theme based activities

June 19– August 2

(Tuesdays & Thursdays)

7 WEEKS

14 SESSIONS

The Speech Language Learning Center

Program cost: $649.00

50% deposit required at registration.

Balance due by July 10

Call (810) 733-3911

by June 2 to register

Individual therapy also available!
Please call to inquire
(810)733-3911

Our summer program provides Speech & Language therapy and Occupational therapy in a small group setting using theme based activities. The group is facilitated by a Certified & Licensed Speech Language Pathologist and Occupational Therapist.

Ages 2-5 10:00am-11:30am
Ages 6-11 1:00pm-2:30pm

Speech & Language Disorders

- Difficulty understanding and expressing thoughts, ideas & feelings
- Difficulty with producing age appropriate sounds

Fine Motor Skills

- Handwriting
- Scissor cutting
- Zippers/Buttons

Gross Motor

- Balance
- Strengthening
- Coordination

Sensory

- Exploring different textures through touch, sound & taste

Ages 12-16 3:00pm-4:30pm
Social & Functional Living Skills Group

- Greetings & Friendships
- Chores
- Grooming & Hygiene
- Emotions & Strategies
- Behaviors & Consequences
- Social Media & Cell Phones

The Speech Language Learning Center
2413 South Linden Road ▪ Suite B
Flint, Michigan 48532
(810)733-3911 (810)733-3912 info@sllcenter.net

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Flint Township, MI 48532
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Client Information Sheet (child)

Date: _____

Client Full Name: _____

Date of Birth: ___/___/___ Age: ____ Sex: ___

Telephone: Home #: _____ Cell#: _____

Home Address: _____

Mother's Name: _____

Father's Name: _____

Sibling's/Ages: _____

Primary Care Physician: _____ Phone #: _____

Others Living in the Home: _____

Languages Spoke in the Home: _____

WHO IS RESPONSIBLE FOR THE CLIENT'S BILLS? _____

_____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Social Security #: _____

Date of Birth: ___/___/___

Employer: _____

Phone # of Employer: _____

Address of Employer: _____

WHOM MAY WE CONTACT IN THE EVENT OF AN EMERGENCY (OTHER THAN PARENT)?

Name: _____

Telephone #: _____

Relationship: _____

Social History:

How does your child play with other children: please check all that apply:

o Cooperative

o Leader

o Aggressive

o Picked on

o Makes friends easily

o Needs to be in control

o Shares well with others

o Extremely shy

List any concerns you may have about your child's social skills:

_____

Favorite toys/activities: _____

Behavior: Please check all that apply to your child:

o No specific problems

o Easily frustrated

o Difficult to discipline

o Short attention span

o Plays well with others

o Easily distracted

o Self injurious behavior

o Redirects with the following supports: _____

Educational History:

Please list schools attended (include day care and preschools):

Dates attended: Name/location/district:

_____ _____

_____ _____

_____ _____

Please describe services:_____

_____

*We will need most recent copy of your child's school IEP

Therapy History:

List any therapy your child has received (When, where, and duration treatment):

_____

_____

_____

_____

Is there any other important information that you feel may be helpful to your child's treatment?

_____

_____

_____

_____

What goals would you like your child to achieve through our summer therapy program?

_____

_____

_____

This information will be kept confidential and used solely for the purpose of providing the appropriate care to your child. Thank you.

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Notice of Privacy Practices

NOTE: This notice describes how speech/medical information about you may be used and disclosed and how you can get access to this information. This is very important, so please read it carefully.

In the course of your care at The Speech Language Learning Center we may use or disclose personal and health related information about you in the following ways:

· Your personal speech/health information, including your clinical records, may be disclosed to another health-care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment. Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, PPOM, or other institution if they are or may be responsible for the payment of your services.

· Your name, address, phone number, and your speech/health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

· Your health records are kept in this office in either a storage location or in the front desk area. Consequently, your name may be visible to others while being kept in these locations. To comply with all current HIPPA regulations, we will do everything possible to protect the privacy of our patients. These records are locked in the office during our off hours. During office hours the records are easily accessible to the employees of this office.

If you're are not home to receive and appointment reminder, a message may be left on your answering machine/voice mail. Likewise, you have the right to inspect or obtain a copy of the information we used for these purposes.

You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you for the reimbursement avenues associated with your care.

Under federal law, we are also permitted to require using or disclosing your health information with out your consent or authorization in these following circumstances:

- If we provide speech/health care services to you in an emergency.
- If we are providing speech/health care services to you based on the orders of another speech/health-care provider.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide you care.
- If we are ordered by the courts or another appropriate agency to act on your behalf.

Any use or disclosure of your protective speech/health information other than outlined above will only be made up on your written authorization.

We normally provide information about your speech/health to you in person at the time you receive speech services. We may also mail information to you regarding your speech services or about the status of your account.

You have the right to inspect and/or copy speech/health information for seven years from the date that the record was created or as long as information remains on our files. In addition you have the right to request and amendment to your speech information. Requests to inspect, copy, or amend your speech/health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and protect speech/health information therein. We are also required to provide you access of this notice of privacy practices with respect to you speech/health information.

Information that we use or disclose based upon this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have any concerns regarding our privacy practices, any aspect of our privacy activities, or would like further information feel free to contact a Speech Language Learning Center Staff Member.

AUTHORIZATION & ASSIGNMENT

____ **Authorization to release information:** You are authorized to release any information you deem appropriate concerning my speech condition to any insurance company, adjuster, attorney, in order to process any claim for reimbursement of professional services rendered by you. I hereby release you of any consequence thereof.

____ **Assignment of payment:** My insurance company is hereby requested to pay direct to The Speech Language Learning Center, Glenda Locke M.A. CCC-SLP, any monies due on my account. Further, I agree to pay any outstanding balance after my date of service if completed by the insurance company. I understand that I am responsible for the payment of this account, and that our professional services are rendered to you, **not the insurance company**. Therefore, payment for treatment is **my responsibility.**

____ **Consent to care for a minor:** I hereby authorize The Speech Language Learning Center, Inc. as they deem necessary to my relative:

_____.

I understand that I may be responsible for collections fees incurred if it becomes necessary to turn my account over to collections.

I acknowledge I have read and fully understand the above statements and agree to the terms outlined.

Patient's Name: _____

Patient's/Legal Guardian's Signature: _____

Date: _____

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Parent Release Form for Media Recording

I, the undersigned, do hereby grant or deny permission to The Speech Language Learning Center to use the image of my child,_____,as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on The Speech Language Learning Center website.

____ Deny permission to use my child's image at all.

____ Grant permission to use my child's image in the following ways (mark all that apply):

____ **Limited usage:** I want my child's image used within The Speech Language Learning Center setting only.

____ **Limited usage:** I want my child's image used for educational materials only (not marketing). This could be either within The Speech Language Learning Center or in larger community. One example of this could be videos in parent education classes.

____ **Limited usage:** I want my child's image used on printed materials only (no digital or video use).

____ **Unrestricted usage:** I give unrestricted permission for my child's image to be used in print, video, and digital media. I agree that these images may be used by The Speech Language Learning Center for a variety of purposes and that these images may be used without further notifying me. I do understand that the child's last name will not be used in conjunction with any video or digital images.

Parent/Guardian signature:_____Date:_____

Glenda Locke MA CCC-SLP/President

The Speech Language Learning Center