

Innovative Therapy Service

Pediatric Speech-Language Services



Expect the best in learning Speech, Language and Social Skills

1090 Homestead Rd.
Santa Clara, CA 95050
Phone/ (408) 241-2229
Fax/ (408) 241-3156



***UPDATED PARENT
HANDBOOK updated 2025***

Welcome to Innovative Therapy Services (ITS). ITS was established in 1998, with the vision of treating the “Whole Child.” Innovative Therapy Services is a friendly therapeutic clinic with multifaceted features. We know a strong partnership with you will make a great difference in your child’s education. As partners, we share the responsibility for our children’s success and want you to know that we will do our absolute best to carry out our responsibilities.

Our Mission

The mission of **ITS** is “to build long-term relationships with our clients through quality speech and language services and great parent supportive programs.” We believe to meet our mission we must create the three S’s:

“Successful Treatment for all
Clients **S**upportive Work
Environment **S**trive to Improve
Ourselves **”**

This 2021 handbook is our newly revised handbook and replaces all previous policy handbook. We advise you that you review and sign the last page.

The speech/language therapy is individualized and tailored to meet your child’s speech/language needs. To elicit the target behavior/s (speech or language), we use tactile prompts, signs, and a variety of materials (toys, books, games etc.) during the therapy. Frequency and duration of therapy is dependent on the child’s attention span, need and age. Therapy sessions can be scheduled for 60 minutes, 45 minutes or 30 minutes between one to three times per week.

We strive to maintain a friendly and welcoming atmosphere at ITS. Please do not hesitate to ask questions. However, be aware that therapists are "on duty" with their client during the therapy times, including before and after your child's speech sessions and cannot stop to talk with parents beyond allotted therapy times. **We offer a consultative therapy program, if you feel you need more time to discuss your case please make an appointment so that you can have the therapist's full attention.** Therapists check their emails and messages daily and return all calls and messages within 24 to 36 hours. From time to time, the email server can go down or a therapist's computer may need repairs. Therefore, it is wise to call the office if your email message is not returned in a timely manner (408) 241-2229.

1. If you have a question about how your child is doing in therapy or a concern about something happening in the therapy sessions, e-mail the therapist OR make an appointment to meet with the therapists. If you have ongoing conflict with the therapy sessions please make an appointment to speak to the therapist and the director, Uduak Osom. There will be no additional charge for the meeting.
2. If you have a question about ITS policy or procedure email Uduak (Udie) Osom, Director or call the office.
3. If you have a question about your billing, account and payments call and ask to speak to the office manager.
4. If you are unable to get your question answered to your satisfaction e- mail the director Udie OR leave a message with the office requesting that the Udie return your call 408-241-2229.

The Listed fees are not applicable to Regional Center Services and Kaiser Clients

Standard clinic fees for therapy times are as follows: Please don't ask us to bill your insurance. Currently, we have no affiliations with private health insurance companies, but Kaiser. We will also not bill your insurance as a 3rd party provider. Please see the rate breakdown below:

Standard clinic fees for therapy times are as follows:

We will continue to provide scaling fees for our clients - self-paying only:

- **Billed per 60 minutes individual therapy is \$230.00**
- **Billed per 45 minutes individual therapy is \$197.00**
- **Billed per 30 minutes individual therapy is \$161.00**
- **Group Social Skills therapy is 198.00**
- **AAC ongoing support therapy is \$237**

Early Pay Discount: We will continue to give 4% additional discount if therapy fees are paid in full at the beginning of the month. This discount excludes credit card payments. Clients with co-pay, off site therapy or promotional discounts do not qualify for discounts. Cannot be compounded by other discounts.

Discount is not offered for Home/offsite or Saturday Therapy.

To Qualify: client must pay for the full month (partial month attendance does not qualify), pay by check, cash, or money order – credit card payment is not accepted for discount. Payment must be submitted by the first session of the month.

Late Fee: families are given a grace period of 7 days from due date before a late fee is assessed. A flat rate of \$15 is charged to the account per week thereafter.

- **In Home/On Site Therapy Fee: \$247.00 per session:** ITS clinicians visit the home to conduct speech, language, feeding and swallowing therapy. Client/Family must adhere to the terms and conditions of in-home therapy as stated in the Financial Agreement - Terms & Conditions Form. Limited to 5 families at a time.
- **Saturday Therapy: Fee: \$245.00 per session:** Available for all pediatric ages (12 months – 15 years); when conditions are deemed feasible, the ITS office is opened up on Saturdays for services – evaluation, screenings, assessments, speech & language therapy. Check in with the office for updates on Saturday therapy.
- **Consultative Service - Parent and other Providers \$247.00**

Evaluation Fees

- **AAC Assessment:** (All ages) includes comprehensive receptive and expressive language or and Augmentative and Alternative Communication -Include device choices and report **\$1010.00**
- **Comprehensive Oral Motor Evaluation and Feeding Evaluation:** (all ages) includes dysphagia/swallowing or feeding assessment and an analysis of oral motor musculature weakness and its effects on speech sounds. **(\$1010.00-)**
- **Global assessment:** (4-18 years) includes comprehensive receptive and expressive language or language-processing disorder, articulation, and oral motor **\$1010.00**
- **Articulation/Apraxia/ Phonology-** **\$1010.00 (All ages).**
- **Global assessment:** (2-3 years) includes comprehensive receptive and expressive language, articulation, and oral motor. **\$878.00.**
- **Global assessment:** (0-2 years) includes comprehensive receptive and expressive language, articulation, and oral motor. **\$781.00.**
- **Receptive and Expressive Language Assessment:** (4 –18 years) receptive and expressive language evaluation (with no other types of assessment included) **\$900.00.**
- **Receptive and Expressive Language Assessment** (2 –3 years): receptive and expressive language evaluation (with no other types of evaluation included) **\$800.00.**
- **Comprehensive Pragmatic language/meta-cognitive:** includes functional language assessment, problem solving, inference, language use and situations. **\$1000.00.**
- **Consultative Therapy Evaluation & Annual Re-evaluation Report:** (This applies to all ages) Your child will be given testing and as well as treatment, but your services will be billed as consultative therapy, at our regular therapy rates. You will be billed according to the duration and number of times your child is seen. For example, if your child is seen twice for thirty minutes, you will be billed for the therapy rate that applies for such service. You have a choice of receiving a written summary report of our findings (includes treatment plan) at the cost **\$410.00** or not to receive any written report, but ***just the treatment plan for free. Please note if in the future you decide that you would like a written report, you will be charged \$660.00.***
- **Insurance Progress & Annual Report:** *For all clients*, if we conduct an evaluation for your child, you will be charged our regular therapy rates (as stated on page 6), in addition to the evaluation, we will bill at **\$400.00. Please note if in the future you decide that you would like a written report, you will be charged \$650.00.**

Evaluation Procedures

The speech/language evaluation is conducted in two to five visits at the clinic, depending upon the needs of the child. At the completion of the evaluation an extensive report will be provided to you detailing our findings, recommendations, and an individualized treatment plan (if therapy is recommended). The results and recommendations of all evaluations will be reviewed with you (two weeks after the completion of the written report). Please download and complete the questionnaire to expedite your child's evaluation process. Some questions may not apply to your child, or the information may be difficult to recall. Please answer as best as you can. It is important that this questionnaire be completed and returned prior to the first appointment, as this will be used to determine the evaluation procedure and the types of tests to administer to your child. Be assured that all information will be kept strictly confidential. Please attach other evaluations your child has received. As we are a private agency we do not solicit reimbursement from public schools. Therefore, if you intend to receive reimbursement for our services please discuss this with your Individual Educational Plan (IEP) coordinator.

Family Supportive Services

As a child and family centered practice, ITS works hard to meet the growing needs of our clientele. ITS offers auxiliary services during periods of the year when schedules and resources are expendable. The clinic opens the auxiliary services based on time, availability, distance, and accessibility. The coverage area reaches a 15 – 20-mile radius from the ITS clinic. You can check with the office for updates on openings for the following services:

Individualized Educational Plan

- Explain and describe your child's progress in our program
- Collaborate with other professionals

Fees:

- One-half –day fee **\$1010.00**
- I.E.P attendance **\$247.00** per hour (off site consultation fee rate).
- Reading / Editing Report: **\$210.00** per hour (not to exceed 3 hours)

****For the I.E.P we calculate from the time the meeting is scheduled to begin.***

Other Consultative Services

Email is usually the best way to communicate with your therapist however, with respect to time and comprehension, ITS offers the following:

- **Teacher Consult:** parents sometimes ask that the speech therapist consult with their child's teacher or speech therapist via phone or personally. This requires an "Exchange of Information" form to be completed by the family and payment of services after the event occurred. \$242.00/per hour
- **Parent Consult:** parents sometimes want to sit down with their child's therapist to discuss in depth, supportive services for the home, school, IEP, etc. \$242.00/hour
- **Phone Consult** (exceeding 10 minutes): clients are welcomed to communicate with their child's therapist however, phone consultation over 10 minutes is charged at \$64.89 per 15 minutes or any fraction thereof.
- **Reading / Editing Reports:** \$210.00/hour

Late Fee: assessed to account after 7-day

Payment
Options



We accept a variety of payment methods and offer choices for our clients to pay for services within a flexible payment schedule. They are as follows:

We accept:

- Visa, MasterCard, HSA (flexible spending accounts)
- Checks and Money Orders
- Cash
- **Prepay Monthly:** you have the option to prepay services for the entire month. The payment is billed and charged two weeks before the first of the service month.
- **Weekly:** you will be billed on the last session of the week.
- **A 5% discount is applied if the entire month of service is paid by the first week of that month. In order to apply the 5% discount, payment must be by check or money order, cash or zelle.**

Health Insurance

- We have terminated billing of 3rd party and additionally we will no longer submit claims for clients. However, for our current client that we had agreed to bill. We will continue to honor our agreement. However, any outstanding balances, copayments and deductibles are due prior to checking in for your appointments. Please note that until you meet your deductible, the payment will be applied by your insurance company towards your deductible.
- We will return all payments from insurance companies sent to us for claims we did not submit. Please do not ask us to cash any checks or credit cards from your insurance. You are responsible for contacting your insurance to re-issue your checks.
- **For the insurance company that we are in contractual agreement with, we will expect payments within contractual agreement terms. However, if your insurance fails to pay, you are responsible. All co-payments, co-insurance and out of pocket are collected on the day of services, when we check your benefits. At this time we are only in contractual agreement with Kaiser Permanente.**

Important Notice

1. We will provide superbill to all clients. The superbill will include your child's information, diagnostic codes, NPI for our clinic, Tax ID and dates of services.
2. **We will also provide documents via email for you to submit to your insurance if the insurance request the documents. We will only submit documents for clients that we have contractual insurance agreements with or otherwise it is the client's responsibility to collect all the documents needed from our clinic and submit them.**
3. **If your insurance company request a month worth of treatment notes, please note it will take 2 to 3 business weeks. You will be notified by email upon completion of gathering the documents for self-pickup or we can send the documents vial docusign for you to print and send to your insurance company.**
4. If we must conduct an evaluation for your insurance purpose, our standard charges for re-evaluation will apply to re-evaluating clients for medical insurance purposes.
5. **Please Note: It is the client's responsibility to follow up on the status of the insurance claims once submitted by ITS. Should there be a discrepancy or further information needed from ITS, the clinic will assist in rectifying that discrepancy.**

IMPORTANT REMINDERS

Most insurance companies will list speech therapy services as a reimbursable service, but not all speech services are covered within this category. In order for the speech therapy to be covered by any insurance company, there has to be a medical condition causing the speech problems. **We recommend that you first check with your insurer as to their exclusions and requirements. We also require that you bring a prescription from your child's pediatrician referring your child to Innovative Therapy Services and specifying the need for speech therapy intervention. All parents planning to file claims must sign our Insurance Claims agreement along with your financial agreement forms.**

Verifying Coverage (We Will Need)

- **Medical information (medical card, signed authorization to contact insurance)**
- **Contact information of your insurance company to verify coverage.**
- **Doctor's Prescription for speech therapy (some insurance companies require this).**

Information Regarding Teletherapy

We have been providing teletherapy services to the pediatric population with varied needs and disorders through HIPAA compliant video conferencing. The company staff is trained and experienced and takes pride in the effectiveness and quality of virtual services. We have provided both direct services as well as indirect services (e.g., parent and teacher training and consultations). We have found our clients very successful with this mode of therapy. Family and parent involvement is always highly encouraged, and a parent must present during sessions, regardless of age. Parents with children from ages 18 months to 6 years are mandated to participate during the teletherapy sessions. The therapist will be using a platform that includes built-in worksheets, apps, games, and hands on resources. The client and parents can see what the therapist displays over the computer, and they can actively participate using the platform (type on the screen, draw, play games, etc.).

All therapy will be directly targeted to address the child's goals. Videos and books are also available online for therapists to use during sessions. Therapist /parent collaboration is a must to ensure carry over and generalization to the home and community settings. The Company does not provide this equipment to families but are ready and willing to begin services for any families interested in receiving teletherapy immediately. Teletherapy is definitely not for all children and is not "100% guaranteed to work." Some children do better in one-on-one settings, while others prefer to be in a group and not singled out. If you and your therapist agree that your child would benefit from teletherapy, there are few steps to ensure successful payments. Insurance coverage of teletherapy for online is a complicated issue. A person's state, insurance provider, telehealth provider and treatment plan can all influence what is covered. Treatments in some states can be eligible for full coverage, while others are only eligible for telehealth reimbursement or not at all. Because of these differences, it is essential to contact your insurance provider to confirm your specific plan's benefits, requirements, and allowances. Teletherapy insurance coverage often depends on:

- **Patient setting.** Where is the person receiving services? Some states will allow the person to be at home or school, while other states require the client to be in an office setting.
- **Technology used.** Telehealth technology includes voice and video chat in real time, as well as remote patient monitoring and options to record and send messages. Some states and companies allow all these options, while others require telehealth to occur in real time.
- **Specific insurance.** Coverage will vary greatly by company and plan.
- **Licensure-** The clinician must be licensed in the client's primary address/state otherwise we cannot provide the service.
- A parent must check and confirm that teletherapy is allowed, please be sure to get pre-authorization (if required) prior to your appointment session.

**Innovative Therapy Services Therapy
Pediatric Speech, Language and Social Services
Teletherapy Technology Services**

User Agreement and Acceptable Usage Policy for Speech Therapy Agreement

Acceptance of Agreement

Zoom is a web and video conferencing service provided by ITS for the sole purpose of providing speech therapy to clients. This agreement governs the use of the Zoom therapy service and is in place to ensure compliance with all applicable ITS-Peds and HIPPA security policies and standards and California speech and language pathology standard of services.

ANY USER SIGNING INTO ZOOM in representation of ITS-peds. WILL BE ASSUMED TO UNDERSTAND AND AGREE WITH THIS USER AGREEMENT AND ACCEPTABLE USAGE POLICY.

Any User who does not understand or agree with the policy should not login to the system.

Updates to Agreement

ITS-peds. may update this User Agreement at any time and without notification to reflect its organizational needs.

Service Description ZOOM will be used to provide speech therapy services

1. Secure web and video conferencing and telepresence.
2. Prescheduled conference set up and support.
3. Password protected meetings.
4. Meetings may not be recorded, and no streamed playback used.

Acceptable Usage Policy

1. Use of Zoom with ITS clients is for the purpose of ITS business only.
2. Users will not use or present any content that is in violation of state or federal laws or ITS-peds. policies.
3. It is the responsibility of the User to make all attendees aware in advance of any other attendees for the session and must receive consent from parents in advance.
4. Inclusion and sharing of Protected Health Information (PHI) must adhere to all HIPAA policies and guidelines.
5. Users must obtain consent from appropriate parties prior to including, recording, or sharing any content containing sensitive information (e.g. protected health information, intellectual property, copyright material). If needed, our Patient Release and Authorization Form and General Recording and Release Form can be downloaded and must be obtained from parents prior to any form of recording that can occur, this includes audio recordings etc.
6. Any use of this service is the responsibility of the User. ITS will not assume responsibility for the misuse of content.
7. The user agrees to comply with all applicable ITS security policies and procedures and HIPPA laws.
8. Users understand that while teletherapy is appropriate for intervention, some goals may have to be modified due to the limitations of access to direct Face to Face contact.

9. The user understands that in some cases use of teletherapy does not substitute for Face-to-Face direct intervention, but in some scenarios the child does benefit from zoom therapy.
10. ITS will not assume responsibility for content that is reported or discovered to be in violation of any policies or laws. Any recorded content will be removed pending review, and appropriate action taken if necessary.

All services and client services will be kept confidential and information must be shared via ITS email accounts. Services rendered must be documented in treatment notes as always and submitted at the end of each month.

- **Treatments must follow goals outlined in the client's report**
- **Parents must be intricate part of the delivery model**
- **Activities must be emailed to families and instructions and accommodations needed must be explained in advance.**
- **Written homework must be provided at the end of the week, as needed**
- **Families must be provided resources to continue with services**
- **Issues related to services must be brought to the attention of the director immediately.**

Limitation of Liability

1. ITS will have no liability or responsibility in the event of any loss or interruption of the services and/or media content described within this agreement due to causes beyond its reasonable control or ability to foresee.
2. I understand that due to the current emergency, ITS will bill all clients that pay weekly, monthly in advance and any sessions not utilized will be provided a makeup.
3. If the client was sent a reminder, but the client did not confirm, given the challenges of COVID
4. 19, the session will be charged, however the session will be rescheduled.
5. Makeup will not be provided for clients that cancel sessions 20 minutes prior to the scheduled session.

Termination of Service

1. The intended use of the service by the client is not allowed, unless is within the scope of agreed scheduled services and times.
2. Clients intended use of the service is for the purpose of speech, language, articulation or functions related to therapy. If the Zoom causes a situation that conflicts with ITS model or professional relationship, the said service must immediately be terminated.
3. The intended use of the service by the client does not match the services that ITS policies.
4. The client has not followed through with the proper procedure for requesting the necessary service.
5. The client has been previously found to be in violation of any ITS policy within such as not attending the session regularly as scheduled
6. The client or therapist does not comply with ITS policies outlined in the Parent and therapist policy handbook.
7. The client and therapist must comply with HIPPA laws
8. Termination of service will be at the discretion of ITS management based on the following:

Violation of the effective User Agreement or any Service Level Agreement (in ITS HANDBOOK) in place.

1. It has been determined that the client's or therapist's use of the service is matching circumstances that would have ordinarily caused a denial of service.
2. The client's or therapist's use of the service is directly causing a negative impact on the quality of service.
3. Any other reason agreed to be appropriate that is deemed inappropriate.

Social Skills Groups & Summer Camp

At ITS, we have two successful social skills programs that we offer: the **Pride in Learning Social Skills (PLSS) Camp Program** offered in the Summer and our **ALL for 3's group** (offered throughout the year). Both of these groups are led by licensed therapists. In both groups, the therapists may utilize behavioral reinforcement to promote rule compliance, participation, and use of appropriate social skills, while also encouraging and reinforcing the children to practice these skills outside of the session. Objective information regarding the children's behavior will be gathered before and after the group to measure the children's progress. Parents will be provided with written feedback at the conclusion of each group.

- **All for 3's:** The purpose of this group is to facilitate desirable social communication interactions. All for 3's groups focus on teaching the children a variety of social communication skills to help improve their ability to make and keep friends, develop more self-confidence and get along with others. The All for 3's social group program is a 14-week cycle that meets for one hour, one time each week. Groups typically consist of two to three children, with a licensed speech pathologist leading the group. We offer 5 different social skill groups: *Tweets (10-14 years)*, *Lions (7-9 years)*, *Sharks (5-8 years)*, *Penguins (3-6 years)* and *Puffins (2-3 years)*. **Fee: \$198.00**
- **Pride in Learning Social Skills (PLSS):** An expansive and more adventurous version of the All for 3's social skills groups, PLSS hosts two 4-week programs of summer activities and outings that focus on and develop your child's social-emotional and problem solving skills. The camp meets for 3 hours, twice a week. All participants are screened for current skills and written individualized social skill goals. Parents receive the goals at the start of the program and are given a written report at the end. **See summer package for rates.**

Procedure for Scheduling Therapy

At ITS, official clinic-wide schedule changes **occur twice a year, in the fall and in the summer.** While we attempt to accommodate client's preferred times, there are no guarantees.

1. We do not make promises, a preferred schedule is what we strive for, but sometimes we are not always successful.
2. Therapy slots are allocated according to the following scale: (1) client need / severity of diagnosis (2) therapist availability & compatibility with client (3) early intervention/medically fragile (4) longevity / consistency in attendance.
3. We generally advise parents to accept the times we have available and put their request on a waiting list for their preferred times. Please know that your Fall therapy schedule will not carry over for the Summer schedule (and vice versa), you must request it.
4. We will not change schedules after parents have agreed to the assigned slots, regardless of if your child has other scheduling conflicts (such as adding a new program, changing times within your child's current programs etc.). Changing schedules impacts, other assigned clients, and therapists.

Schedule Request Procedures

Fall Schedule: By the 2nd week of July, the Preferred Schedule Request Letter is available and distributed to parents. By August 31st, parents are given their scheduled therapy times. **Summer Schedule:** By the 2nd week of April, the Preferred Schedule Request Letter is made available and distributed to parents. By May 31st, parents are given their scheduled therapy times.

Observation of Holidays

As with most agencies, we observe holidays, such as 4th of July, Thanksgiving,

Christmas's eve, Christmas, New Year's Eve, New Year, therefore during those times, we temporarily shift therapy schedules to accommodate these holidays. Be assured you will be given plenty of opportunities to adjust your schedule, prior to such changes. We will do our best to not disrupt your child's therapy as that is our number one priority. With that said, we will email you to provide makeups for those Holidays.

Home Speech Therapy Program

PURPOSE

With home speech therapy, a speech therapist comes to your home. This can be your private residence, a family member's home, or at a designated community place. In all circumstances where home visits occur, parents must ensure the safety and security of those who undertake such visits on behalf of Innovative Therapy Services. With our home speech therapy program, a parent must be present or a designated family member (authorized by the family) must be present. The therapy is family centered as we recognize the important role you play with your child. We will coach you and support you during our sessions and additionally, we will provide homework for you to continue to support your child. This means that therapy goals, activities, will be collaboratively as we are a team. Information and treatment is directly tied to your child's goals and objectives.

Home Visiting Policy

In all circumstances where home visits occur, parents must ensure the safety and security of those who undertake such visits on behalf of Innovative Therapy Services. The purpose of this policy is to establish protocols and procedures that provide people undertaking home visits with a high level of safety and the means to avoid or manage potentially dangerous situations.

POLICY

1. Upon arrival at the home, if the clinician feels unsafe, the clinician will immediately terminate the visit. The parents are responsible for payment for the terminated services.
2. Therapy will begin immediately upon arrival; therefore, parents must designate an area for the therapist.
3. Therapy will end 5 to 10 minutes prior to set time, in order for the therapist to pack and also review the therapy session with the parent.
4. Please if you have animals inform the therapist for safety reasons as some people are allergic to animals or are afraid of animals.
5. Dogs must be kept on leash and away from the clinician.
6. If the therapist arrives and the family is not home, after a 5-minute wait, a note will be placed on the door and the therapist will leave. Please note you will be charged for the session and if the visit is a makeup, no new makeup therapy will be offered. We expect a 24-hour notification of cancellation of the home visit.
7. No home visit will be undertaken unless the parents have signed this agreement.
8. To avoid unwarranted allegations of impropriety, unaccompanied parents are requested to be present at the house or in the room during the sessions.
9. If we find that the family is not ready for the home visit nor have taken the necessary steps to ensure the safety of our clinician (s), all future planned visits will be terminated, and the family will be asked to bring the child/children to the clinic.

HIPAA Privacy Rule

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health information. At the same time, the Privacy Rule recognizes circumstances where health information may need to be shared to ensure the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others. The Rule is carefully balanced to allow uses and disclosures of information—including mental health information—for treatment and these other purposes with appropriate protections. The Privacy Rule permits covered health care providers and other covered entities to disclose reports of child abuse or neglect to public health authorities or other appropriate government authorities. See [45 C.F.R. 164.512\(b\)\(1\)\(ii\)](#). Thus, there is no conflict between the State law and the Privacy Rule, and no preemption. Covered entities may report such information and be in compliance with both the State law and the Privacy Rule.

Privacy Policy & HIPPA Law Speech Pathologists, amongst various medical professions, must abide by the Health Insurance Portability and Accountability Act (HIPPA). HIPPA serves to improve and protect the nation's health care system. More specifically, ensure that your information is kept secure and treated confidentially. ITS employs various measures within our clinic in order to comply with these HIPPA guidelines. Please be aware that however banal the question ("Do you mind if we talk here?") or tedious the paperwork (authorization of release of information forms), it is for your protection. The law obligates us to give notice to clients' regarding their privacy rights.

- We cannot disclose client private information to any agency outside of this office without written consent from the client, with the exception of the child's welfare.
- At ITS we do not discuss any client cases in the public waiting areas. All discussions regarding the client must occur in a private clinical room, both with parents and clinicians. The therapist upon completion of therapy must invite the parent into the clinical room to discuss outcome and homework in the treatment rooms.
- The law prohibits clinicians from discussing clients with other parents unless parents have provided a written consent.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Authorization I the parent
of _____ authorize _____ (healthcare
provider) to use and disclose the protected health information described below to
_____ (individual seeking the information).

Effective Period This authorization for release of information covers the period of healthcare
from:

a. ☐ _____ to _____. b. ☐ all past, present, and future periods.

b. I authorize the release of my complete health record with the exception of the following
information:

- ☐ Mental health records
- ☐ Communicable diseases _____
- ☐ Speech therapy records and notes
- ☐ Other (please specify): _____

Parent Signature _____

Date _____

Cancellation Policy

1. Although we hold a **zero-tolerance cancellation policy**, Innovative Therapy Services understands that emergencies and unforeseeable things happen well within a 24-hour period. Therefore, you will be given a makeup for missed sessions, as long as we are given 24 hours notices.
2. **Makeups**: to receive a makeup session, clients must adhere to the 24-hour notice. Clients will be billed on the same day of the canceled therapy session. Please be aware that makeups will be provided for canceled sessions within 1-2 months of the cancellation. If our therapist cancels sessions, we will attempt to schedule a makeup session within two weeks of the canceled session.
3. Makeups provided for any session canceled by the client are considered a courtesy, as you pay for slots when you enroll your child at ITS. **We will attempt five times to work with you to schedule your makeup (s) within the two months period of missed session (s). If the client refuses offered makeup session (s) after the fifth attempt, it is assumed that the client has forfeited the makeups.**
4. All attempts will be made on our part to work with families to make cancellations by any therapist at the clients best available times.
5. **All canceled sessions are billed**: It is the client's discretion to make up the canceled session. Clients are charged for all canceled sessions, with the exceptions, of medical emergencies, of which the client must bring a written note from the doctor/ death in the family. This is necessary because a professional time commitment is set aside exclusively for the client.
6. **The family MUST email cancellation with 24 hours' notice or leave a voice message at (408) 241-2229. It will be considered a "No show" when the office does not receive any kind of notification of cancellation. "No Shows" are billed to the client and cannot be made up without a written note/excuse for a medical emergency, etc. No Shows are billed as our regular therapy fees.**
7. Clients that we bill their insurance are responsible for the therapy fees of missed sessions. Any missed or canceled session cannot be submitted for claims to any insurance (even if you have paid in advance). You can only submit claims for dates serviced. We will issue another superbill on the day the session (s) has been made up. Makeups are not guaranteed to be provided by your regular assigned therapist. However, we will make sure that the therapist is provided all necessary information to make your child's session a success.
8. **Vacations**: We all need vacations; we will inform you of our clinicians planned vacations and provide coverage for all vacations. Please recognize that our clinicians have earned PTO and by law, they must take their PTO, therefore your child will be seen by another clinician. We understand that families must and should take vacations. Please inform the front office of your planned vacation 2 weeks in advance if you are planning to travel for about a week. We will arrange makeup prior or after your return date. **We do charge in advance for all missed sessions prior to giving courtesy makeups. If you are planning to travel for 2 weeks or more, please inform the front office a month in advance and we can immediately arrange makeup for your planned trip. Please note, you will be billed for the slots. You are welcome to withdraw from our services, and upon your return you can contact us and if we have availability, you will be re-enrolled. Please note that if you do not request to withdraw, we will continue to bill you for the services as we assume that you plan to continue with makeup provided upon your child's return.**
9. **Termination of Services due to frequent cancellations**: Clients must maintain consistent attendance. If a client cancels more than 4 sessions in a month, without a medical reason, the family will be withdrawn from the program and placed on a waiting list until the child is able to attend therapy sessions consistently. Once the client is placed on a waiting list, there is no guarantee that the client will get the previous schedule. In order for the client to be reinstated, the family must provide a written documentation of the medical necessity for all the canceled sessions. This requirement excludes pre-planned vacation. Clients are required to inform the office about planned vacations 2-weeks in advance so makeups can be arranged in advance.
10. **Therapist Cancellations**, when therapists cancel, as a courtesy to the clients we have to schedule a makeup ASAP with the therapist on her available times.

Therapy Etiquettes

1. Clients are not allowed in the treatment rooms without supervision before or after scheduled therapy. It is the responsibility of the parent to comply with the ITS children supervision policies.
2. Therapists are responsible for the client's safety, up until the client(s) has been safely and directly handed to authorized person (s).
3. From time to time, you may be asked to show your ID, as all therapists must be certain that the person(s) taking the child/children from the clinic are listed on the "authorized to pick up form." A client can only be taken from a therapist's supervision by authorized adults. Authorized adult(s) refers to: "Someone the parents have signed consent to pick up the child or someone the parent(s) has informed the therapist (s)/ office manager will pick up the child/children from the facility. If the person is not in the sign consent log, you must verify by phone prior to ITS releasing the child to the person.
4. No CHILD can be left unattended in the waiting room for any reason, NOR can they play in therapy rooms after his/her therapy has ended. It is the policy of this clinic that a parent may not leave the building without informing the office of how to reach them, in case of an emergency.
5. Procedures to address late arrivals and pickups: We schedule therapy according to availability. We do not extend therapy due to late arrival and we terminate therapy 10 to 15 minutes prior to the end of each session to allow time to discuss homework with care providers.
6. It is mandatory that parents with children under the age of 5 not leave the building, except in extreme circumstances. If the parent must leave we must be provided with an emergency contact number, (so we can reach them).
7. A parent/care provider cannot be gone longer than their assigned therapy times. If a parent is 5- 10 minutes later than therapy completion time, they forfeit their discussion/homework times. For example, therapy is 45 minutes, and the therapist completes therapy at the expected time frame of 35 to 40 minutes, and allots the time to discuss homework or treatment results and the parent is not available, the therapist will continue to see the child, however, the parent will not have the opportunity to discuss treatment outcome or homework, as the therapist must spend the remaining time finishing office notes, prepping or see another client.
8. If the parent or care provider is more than 10 minutes later than their allotted time, the following procedure is used: **Parents will be charged for the late time.**
 1. **10, 15, 20, 25+ minutes late pick up billed at \$84.50 30+ --45 minutes late pick up is billed at \$113.25, 45+ 60 minutes, \$121 and so forth**
9. If you arrive late for your session, note therapy begins when you arrive, and it is terminated at the time allotted to your child.

Quality Assurance

- **Best Practice** – A way or method of accomplishing a function or process that is considered to be superior to all other known methods. ITS has put into practice procedures and guidelines to ensure that our clients are provided with the optimal speech and language therapy.
- **Community Participation** -The key to empowering our client in continuing to attend therapy is ensuring that the families take ownership and control of their child's speech and language needs. Participation of patients and their families in their own health care improves the effectiveness of care and enhances patient satisfaction. We treat every family with respect. When families are treated with respect, it increases their self-esteem, and confidence in the services they receive, improving future care-seeking.
- **Team Commitment** to effective teamwork involving all relevant staff cadres for supporting continuous quality improvement.
- **Safety Regulation**- tracking and analysis of quality measures (indicators) as part of routine service delivery using a national pre-establish OSHA, ASHA guidelines to assess quality of services and guide continuous improvement.
- **Transparency**- A culture of safety for patients, health workers and other users of health facilities

HEALTH AND HYGIENE PRACTICE

DISEASE CONTROL Effective exclusion practices can also prevent infectious diseases spreading, thus minimizing harm to adults and children in the care environment. Germs can be transmitted in a number of ways, including, through the air by droplets; through contact with faces then contact with mouths; through direct contact with skin; and through contact with other body secretions (such as urine, saliva or discharges) or with blood.

These germs can survive on hands and objects, for example toys, door handles and bench tops. The length of time a germ may survive on a surface depends on the germ itself, the type of surface it has contaminated and how often the surface is cleaned. It is also dependent upon environmental conditions such as temperature and humidity.

- Washing with detergent and water is a very effective way of removing germs.
- Hand washing is the most important way of controlling infection, the best way to prevent the transmission of disease is to wash your hands well.

ENCOURAGE HYGIENIC BEHAVIOR

Children have the right to have their privacy and dignity respected. The staff at ITS and the ITS families have the right to confidentiality of information relating to medical conditions. However, any illness or infectious disease in a child or adult may impact the clinic. We promote positive interactions with clients by encouraging all staff to practice good health and hygiene practices. By good health and hygiene practice we:

- promote safe food handling
- promote hand washing.
- cleaning bathroom and toilet areas at least once a day
- cleaning toys and other items that children are likely to put in their mouths, after use
- dispose of soiled items in a container that is inaccessible to children, in a hygienic manner.

HAND WASHING POLICY

Hand washing is arguably the single most important means of preventing the spread of infection. Using the correct technique and at appropriate times, hand washing is generally considered to be the best way to avoid getting and spreading germs. Children with special needs need their hands washed as often and as thoroughly as older children. *Thorough hand washing, at appropriate times, can help prevent the spread of all these infections.*

Effective hand washing involves the following steps:

1. use soap and running water: warm water is best
2. wet hands thoroughly and lather with soap
3. rinse hands well under running water
4. pay attention to the back of hands, wrists, between the fingers and under fingernails
5. dry hands with a disposable paper towel or a clean towel. To minimize chapping of the
6. hands (reddening, roughening or cracking skin), pat dry rather than rub them.
7. if you use skin lotion to prevent dry or cracked skin, it should be rinsed off before
8. preparing or handling food.

At ITS hands should be washed:

- before eating meals and snacks
- before preparing or serving food
- after using the toilet
- after wiping the table
- after completion of interaction with each client
- after handling objects soiled with blood, saliva and nasal mucus.
- A bar of soap or liquid soap can be used for hand washing. If reusable containers are used for
- When soap and water are not readily available, alcohol-based hand rubs are acceptable
- Contaminated surfaces
- In cleaning up potentially contaminated surfaces, the following steps must be followed:
- wear gloves, use paper towels to remove as much of the spill as possible.
- Dispose of towels correctly.
- wash all surfaces with warm water and detergent.
- Disinfect the whole area with household disinfectant, as per the manufacturer's instructions to wash hands.

PROTECTING CHILDREN FROM CHILD ABUSE

All states require certain professionals and institutions to report suspected child abuse, including health care providers and facilities of all types, mental health care and providers of all types, teachers and other school personnel, social workers, day care providers and law enforcement personnel. CAPTA "minimum definitions" for child abuse and sexual abuse is outlined below.

1. Child abuse or neglect is any recent act or failure to act: Resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of a child (usually a person under the age of 18, but a younger age may be specified in cases not involving sexual abuse)

DEFINITION - Child abuse means a physical injury which is inflicted by other than accidental means on a child by another person." (Pen. Code 111656.6). The Law defines child abuse as: (1) Physical abuse, (2) Physical neglect, (3) Sexual abuse (4) and Emotional abuse.

1. Physical abuse - Frustrated or angry parent or caregiver strikes, shakes or throws a child. Intentional assault, such as burning, biting, cutting, poking, twisting limbs or otherwise torturing a child, is also included in this category of child abuse.
2. Physical neglect - Severe neglect includes either the negligent failure of a parent or caretaker to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. Physical neglect can also include a parent or caretaker willfully causing or permitting the person or health of the child to be placed in a situation such that his or her person or health is endangered. This includes the intentional failure to provide adequate food, clothing, shelter or medical care. An example of general neglect includes inadequate supervision, such as parents leaving their children unsupervised during the hours when the children are out of school.
3. Sexual abuse - Sexual assault includes rape, rape in concert, incest, sodomy, oral copulation, penetration of genital or anal opening by a foreign object and child molestation.
4. Emotional maltreatment - Verbal assault (belittling, screaming, threats, blaming, sarcasm, unpredictable responses, continual negative moods, constant family discord and double-message communication are ways parents may subject their children to emotional abuse. (Child Abuse Prevention Handbook, California Attorney General's CVPC, Revised by State law authorizes health care providers to report suspected child abuse to the State Department of Health and Social Services.

Safety and Welfare of our Clients and Staff

Goals/Philosophy Safety first, last, and always.

To provide children within the organization the ability to learn and communicate within their community, organized and structured activities which contribute to intellectual, social, emotional, and physical growth.

Parent/Staff Communication

- Communication between parents and the staff is essential to serve the best interests of families and children.
- Parents should not be viewed as “outsiders” or “threatening.”
- Inform parents of any unusual incidents (misbehavior, “I don’t feel good,” lost personal items) as they occur.
- Staff should attempt to always introduce themselves to each parent/guardian.
- Don’t answer questions you don’t feel comfortable answering. Refer them to the appropriate resources.
- Provide information to all families not just to the few who want it or need it.
- Make sure that all information for and from families is clear and linked to children's success in goals.
- Understanding families' background, cultures, concerns, goals, needs, and views of their children.
 1. Respect for families' strengths and efforts.
 2. Awareness of your own skills to share information on child development.
 3. Design and organize a regular schedule of interactive homework (e.g., weekly)
 4. Coordinate family linked homework activities, with home environment
 5. "Homework" at home to mean encouraging, listening, reacting, praising, guiding, monitoring, and discussing -- not "teaching"

Role of the Parent in Recreation Programs

A close working relationship between staff and parents provides the basis for an effective program. The parent’s responsibility in establishing this relationship includes:

- Thorough completion of registration and supplemental information forms.
- Informing staff of any special needs the child may have, i.e., allergies, likes and dislikes.
- Understanding transportation policies.
- Parent/guardian signing in and signing out their child every day of a registered program.
- Picking up child on time.
- Making arrangements for a sick child to be picked up.
- Notifying staff if child is sick or if child will not be attending.
- Making sure child is dressed weather appropriate.
- Talking with staff regarding concerns.
- First aid and emergency procedures
- Police, fire, poison control, and rescue numbers by the phone.

Seatbelts

- will be utilized during transportation periods.
- Vehicle inspections will be conducted.
- Parents must be responsible for installing seatbelts in any vehicle that ITS transports children in

- During fieldtrip it is mandatory that parents drop off and pick up their children. In the event that a parent is unable to drop off or pick up a child an ITS employee may drive the child with a sign permission from parents.

Safety and Welfare of Clients

Physical environment will be clean and free of hazards and provide adequate indoor and outdoor play area that needs to be checked on a daily basis.

Parents will be allowed to observe children during program hours. **DO NOT ALLOW** visitation or release of child to any person who is not listed on supplemental information form. Photo identification must be shown prior to release of participant in structured program. Parent/guradian must sign child out before departure.

Missing Beyond 10 Minutes

- At 10 minutes, the Camp Supervisor, or in his/her absence, the Camp Coordinator will call 911 to alert the police.
- Call the parents to alert them to the situation.
- Follow instructions from the Camp Office and the police.
- Continue to assign some staff to the search.
- Continue supervision of the other campers and continue activities.

Communicable skin conditions:

- Skin infections and head lice are spread through person-to-person contact.
- Early symptoms of head lice are intense itching of the scalp and unusual irritability in children infected with head lice.
- There is no relationship between socioeconomic levels and infections.
- Ages five (5) to eight (8) are the primary prey of head lice.

Skin irritation – (open or oozing wounds, severe skin infections or rashes)

- Isolate affected individual from other participants immediately.
- If a child is affected, call parents and have child taken home.
- The participants may return with a physician's note stating he/she is not putting other participants or staff at risk of infection, and the affected area is properly bandaged.
- Adapt the "Head Lice Letter" to the specific condition, i.e., pinworm, ringworm, impetigo, scabies, and use to notify all parents of participants at your site that a contagious skin infection has been discovered and the problem is being resolved.

Head Lice

- Isolate affected individual from other participants immediately.
- If a child is affected, call parents and have child taken home.
- The participant may return when the facility director verifies the condition no longer exists.
- Use the "Head Lice Letter" to notify all parents of participants at your site that a head lice problem has been discovered and the problem is being resolved.

Contagious Childhood Diseases (measles, chickenpox, mumps)

- Isolate affected individual from other participants immediately.
- If a participant is infected, call parents and have the child taken home.

- The participant may return only with a physician's note stating he/she is free of infection and is no longer at risk to the other children or the staff.
- Adapt the "Head Lice" letter to the specific condition and use it to notify all parents at your site that the illness has been discovered and the problem is being resolved.

Other Infectious Diseases (tuberculosis/meningitis)

- Isolate the infected individual from other participants immediately.
- If a child is infected, call parents and have the child taken home.
- Inform your supervisor of the situation and wait for further instructions.
- Intervention and assistance from the Health Department may be necessary depending on the nature and severity of the illness.

CPR Medication Dispensing There are circumstances when it is necessary to dispense medication to a participant during program hours.

The designated ITS staff person will:

- Dispense prescribed medication.
- Possess the abilities to properly dispense medication and perform treatments in and to monitor potential side effects, and to properly document such.

All Medications:

- Parents/Caregivers are only to send ONE day's supply of medication. All medication is dispensed by a designated staff person as instructed by a physician.
- All medication shall be kept in secured storage in the office with the exception of emergency medications that may be carried by a participant with special written request of the physician, parent/guardian and participant.
- At the end of the day, the parent or legal guardian will be expected to pick up the prescription container from the office.

Prescription Medications:

- No participant will be given prescription medication except upon order from a licensed physician, assigned staff practitioner, physician assistant, or dentist who has the responsibility for medical management of the participant.
- Prescription medication must be in the original container with a pharmacy label listing the participant's name, medication name, dosage, and the prescriber's name. (Prescriber's phone number must be on the label or on file in the office).
- The prescription container shall serve as the prescriber's original order since the prescription is on file at the pharmacy. A written order from the prescriber must accompany any change in medication dosage.
- NO medication from another country will be given.
- NO sample medication will be given unless accompanied by a written note from the prescribing physician/healthcare provider.
- Written parent/guardian request and consent is required (Form "SLP-CPR Medication Dispense Release"). Parent/guardian consent shall be renewed per registered program. The parent/guardian assumes full responsibility for the supply, appropriate transportation, and maintenance of prescription medication.
- When medication is hand delivered by the parent/guardian to the assigned SLP-CPR staff, the supervisor's designee will note the amount of medication received and document on the medication administration record upon arrival of the participant.
- If a medication error occurs, the individual who made the error will do an Incident Report following ITS protocol. Notification shall be sent to the parent/guardian with a request to replenish supplies.
- Such situations require a release form signed by the healthcare provider, the parent/guardian, and the participant.

- The above policy shall not be interpreted to allow a participant to carry any medication a physician and parent should decide upon. This policy gives authorization for life saving/emergency medication only.

Safety and Discipline Policy

At ITS we believe with the use of positive encouragement the clients will learn to grasp the concept of limits and that these limits will help them learn logical consequences. All secure children will test limits. Testing limits is a sign of bonding and trusting. We believe through guided learning the clients will learn the importance of their own space and individuality, therefore, learning about their own actions and how these can impact upon themselves and others.

Strategies we use to encourage positive behaviors at ITS

- At ITS we encourage children to exhibit behaviors that come within a framework set up to recognize the rights of individuals, staff and in groups.
- At ITS physical punishment (e.g., smacking, deprivation of food, use of abusive words) and psychological punishment is unacceptable.
- At ITS expectations for clients will be developmentally appropriate and based on individual development (not on age).

Supportive Approaches

While ITS prides itself on working with and around behavior in the most positive approach available, we cannot always address every behavioral need. Below is a battery of methods and procedures we follow in the clinic.

1. **Redirecting:** In the event of misbehavior, instead of feeding into the child, we redirect the child to another positive experience or preferred tasks.
2. **State Limits:** Setting of limits prevents injury, promotes safety and social interaction and is a major learning process. Limits are defined and clearly stated in a positive manner that is always clear to the child.
3. **Encourage Positive Behavior:** Make a mental note to catch the child in positive actions and reward the child.
4. **Ignoring:** Sometimes it is best to ignore attention seeking behaviors, while encouraging the child to engage in positive social behaviors.
5. **Modeling:** Model the desired behavior to the child.
6. We are consistent, and we use very simple terms.
7. We teach through repetitions and encouragement.

PARENT HANDBOOK RECEIPT

This is confirmation that I have received Innovative Therapy Services Parent Handbook on_____.

Signature

Date

Print Name

Innovative Therapy Services

Pediatric Speech-Language Services



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Santa Clara, CA 95050
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New Client Questionnaire

List up to three areas of need for your child that you would like to target in therapy.
Please list in order of importance.

How do you typically handle your child's mistakes?

How do you motivate your child to do something that he/she dislikes to do?

What is your parenting style? Are: (a) permissive, (b) rule oriented and structured, (c) democratic, or a combination? Describe a scenario that is reflective of your style.

Person completing form: _____

Relationship to the child: _____

Signed: _____ Date: _____

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School-Age Child Questionnaire

General Information

Child's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Zip Code: _____

Does the Child Live with Both Parents? _____

Mother's Name: _____ Age: _____

Mother's Occupation: _____ Business Phone: _____

Father's Name: _____ Age: _____

Father's Occupation: _____ Business Phone: _____

Referred by: _____ Phone: _____

Address: _____

Pediatrician: _____ Phone: _____

Address: _____

Family Doctor: _____ Phone: _____

Address: _____

List the people who live with the child now, age, relationship, occupation/school grade:

What languages does the child speak? What is the child's dominant language?

What languages are spoken in the home? What is the dominant language spoken?

History of the speech and language problem

Describe the main problem/speech-language issues for which you are seeking help.

When was the problem first noticed? By whom?

What do you think may have caused the problem?

Has the problem changed since it was first noticed? Please describe.

How does the child usually communicate? (gestures, single words, short phrases, sentences?)

How does the problem affect the child's behavior/attitude?

Describe how the problem has impacted the family.

What are your expectations from therapy? What are your goals for the child?

Have any other speech–language specialists seen the child? Who and when? What were their conclusions or suggestions?

Have any other specialists (physicians, audiologists, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Are there any other speech, language, or hearing problems in your family? If yes, please describe.

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.).

Length of pregnancy: _____ Length of labor: _____

General condition: _____ Birth weight: _____

Circle type of delivery: ☐ head first ☐ feet first ☐ breech ☐ Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth?

Please describe.

Provide the approximate age at which the child began to do the following activities:

Crawl _____ Sit _____ Stand _____

Walk _____ Feed self _____ Dress self _____

Use toilet _____ Use single words (e.g., *no*, *mom*, *doggie*) _____

Combine words (e.g., *me go*, *daddy shoe*) _____

Name simple objects (e.g., *dog*, *car*, *tree*) _____

Use simple questions (e.g., *Where's doggie?*) _____

Engage in a conversation _____

Medical History

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, tube placement)?

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

Have there been any negative reactions to medications? If yes, identify.

Does the child have allergies? If yes, please list each allergen and describe the child's response to contact with the allergen.

Please describe immediate action to be taken in case of contact with allergen(s).

Educational History

List the schools that the child has attended or is currently attending.

School attended	District/City	Grade level

Are there any academic difficulties reported? By whom? Please describe.

Describe your child's learning style. What helps increase understanding? Is he/she a visual, auditory, or tactile learner?

Are there any behavioral difficulties reported? By whom? Please describe.

Please describe your child's interaction with his/her teachers and classmates.

Does the child receive special services? If yes, describe.

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe some of the goals.

If your child receives homework, how long does it take to complete? How much help is needed?

Family-Social History

Please tell us about your family leisure-time activities.

What are your child's favorite toys/activities?

Please describe how the child relates to his/her siblings.

Does your child have playmates? Describe their play and how your child interacts with others (e.g. shy, aggressive, etc.). What are their ages?

What is your mode of discipline?

Describe any behavioral or emotional issues.

Describe your child's strengths and unique qualities.

Person completing form: _____

Relationship to the child: _____

Signed: _____ Date: _____

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Authorization to Exchange Information Form

As part of our comprehensive evaluation service, we recognize the importance of sharing information with other professionals working with your child. If you wish to take advantage of this service, please complete the EXCHANGE OF INFORMATION form below.

I, the parent of _____, birthdate, _____, hereby authorize Innovative Therapy Services to exchange any and all information contained in his/her record with:

Physician: _____

Phone: _____ Email: _____

Speech Pathologist: _____

Phone: _____ Email: _____

Audiologist: _____

Phone: _____ Email: _____

School Personnel (Teacher/Psychologist): _____

Phone: _____ Email: _____

Other: _____

Phone: _____ Email: _____

Insurance Company (Health): _____

Phone: _____ Email: _____

SIGNED: _____
(Name) (Relationship to Child)

Date: _____

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MEDICAL LIABILITY RELEASE FORM

This Release and Waiver of Liability (the "Release") is between _____ (the "Participant") and Innovative Therapy Services, Inc., and Pride In Learning Social Skills Summer Camp, a social skills program, their directors, officers, employees, and agents (collectively, "ITS").

The Participant desires to work as a participant for ITS and engage in the activities related to being a participant (the "Activities"). The Participant understands that the Activities may include playing and negotiating with children with special needs, participating in ITS building, and traveling to fieldtrip locations.

The Participant hereby freely, voluntarily, and without duress executes this Release under the following terms:

Release and Waiver.

- Participant does hereby release and forever discharge and hold harmless ITS and its successors and assigns from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from the Participant's Activities with ITS.
- Participant understands that this Release discharges ITS from any liability or claim that the Participant may have against ITS with respect to any bodily injury, personal injury, illness, death, or property damage that may result from Participant's Activities with ITS, whether caused by the negligence of ITS or its officers, directors, employees, or agents or otherwise.
- Participant also understands that ITS does not assume any responsibility for or obligation to provide financial assistance or other assistance, including but not limited to medical, health, or disability insurance in the event of injury or illness.

Medical Treatment.

- Participant does hereby release and forever discharge ITS from any claim whatsoever which arises or may hereafter arise on account of any first aid, treatment, or service rendered in connection with the Participant's Activities with ITS.

Assumption of the Risk.

- The Participant understands that the Activities include activities that may be hazardous to the Participant, including, but not limited to, horseback riding, petting animals and traveling to fieldtrip sites.
- Participant hereby expressly and specifically assumes the risk of injury or harm in the Activities and releases ITS from all liability for injury, illness, death, or property damage resulting from the Participant's activities with ITS.

I HAVE CAREFULLY READ THIS WAIVER OF LIABILITY, MEDICAL RELEASE AND INDEMNITY AGREEMENT AND FULLY UNDERSTAND THE CONTENTS THEREOF.
I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN MYSELF AND ITS AND I SIGN IT OF MY OWN FREE WILL.

Participant Name: _____

Parent Signature: _____

Date: _____

Parent Name: _____

(Please Print)

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Authorization is hereby given to Innovative Therapy Services to render emergency medical treatment for any serious injury or illness to my child in the event that I cannot be reached at the time of the accident or illness. I also authorize emergency transportation of my child to a hospital, if deemed necessary.

Parent's Signature _____

Hospital I wish my child to be transported to: _____

Existing Medical Coverage: _____

Member ID/Policy#: _____

Medical Conditions (Allergies, Asthma, Epilepsy): _____

Family Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

EMERGENCY CONTACT CARD

Father's Name		Mother's Name	
Home Address		Home Address	
City, Zip		City, Zip	
Employer		Employer	
Home Phone		Home Phone	
Work Phone		Work Phone	
Mobile/Cell		Mobile/Cell	
Email		Email	

When parents cannot be reached, please contact:

First Name	Last Name	Phone Number	Relationship to Child

Innovative Therapy Services (ITS. Inc.)



Pediatric Speech and Language Services

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Santa Clara, CA 95050
Phone: (408) 241-2229
Fax: (408) 241-3156
www.pediatricsspeech.com

Patient name: _____

INNOVATIVE THERAPY SERVICES EVALUATION FINANCIAL AGREEMENT

1. _____ This Admission and Financial Agreement is applicable to _____ (***write the alphabet pertaining to the type of evaluation you want on the line and also circle the type of evaluation below and initial next to it***). Should your child be enrolled in the summer program or our other programs, be aware that other policies or agreements may be presented. Such policies and/or agreements may be applicable to that program alone, or serve as a reminder to this existing Admissions and Financial Agreement. They do not, in any way, replace this Admission and Financial Agreement unless so specified. This agreement is binding and full fee will be charged.

- a. **Global assessment: includes comprehensive receptive and expressive language or central auditory processing disorder, articulation, and oral motor (4-18 years) \$1010.00** _____
- b. **Global assessment: includes comprehensive receptive and expressive language, articulation and oral motor. (2+-3 years) \$ 878.00** _____
- c. **Global assessment: includes comprehensive receptive and expressive language, articulation and oral motor. (0-24 months) \$ 781.00** _____
- d. **Comprehensive receptive and expressive language evaluation only (4 –18 years) 900.00** _____
- e. **Comprehensive receptive and expressive language evaluation only. \$ 800.00(2+ –3 years)** _____
- f. **Comprehensive Augmentative Communication evaluation report (All ages)\$1010.00** _____
- g. **Comprehensive Pragmatic language/meta-cognitive: include functional language assessment, problem solving, inference, language use and situations. \$1010..00** _____
- h. **Comprehensive Oral Motor Evaluation: includes dysphagia/swallowing/feeding assessment and an analysis of oral motor musculature weakness and its effects on speech sounds. \$1010.00 (all ages)** _____
- i. **Articulation/phonology, dyspraxia: includes oral motor screening and speech sounds analysis. \$1010..00 (all ages)** _____
- j. **Supplementary Evaluations/Re- Evaluations:**
 - l. **Consultative Therapy Evaluation & Annual Re-evaluation Report:** (This applies to all ages) Your child will be given testing and as well as treatment, but your services will be billed as consultative therapy, at our regular therapy rates. You will be billed according to the duration and number of times your child is seen. For example, if your child is seen twice for thirty minutes, you will be billed for the therapy rate that applies for such service. You have a choice of receiving a written summary report of our findings (includes treatment plan) at the

cost **\$410.00** or not to receive any written report, but ***just the treatment plan for free. Please note if in the future you decide that you would like a written report, you will be charged \$660.00.***

- II. Insurance Progress & Annual Report: *For all clients*, if we conduct an evaluation for your child, you will be charged our regular therapy rates (as stated on page 6), in addition to the evaluation, we will bill at **\$400.00. Please note if in the future you decide that you would like a written report, you will be charged \$650.00.**

2. _____ I the parent of _____ have opted not to have an evaluation conducted at this time, but just to receive a one page treatment plan. However, I do authorize the therapist to use one or two portions of my treatment sessions to evaluate my child in order to create the written treatment plan. I understand that I will not be billed for the treatment plan, but just my regular therapy time.
3. _____ We assess a \$25 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office. Moreover, cancelled credit card transactions will result in a 5% charge added to the transaction if it is not paid in full within 24 hours.
4. _____ I/W understand if fees are not paid according to terms that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees assessed in the collection of the debt. These fees include collection agency fees and attorney fees.
5. _____ As a shielding measure we obtain secondary forms of payment such as credit cards. We may obtain your credit card information to have it on hand in the event you are delinquent in your payment. If you have not paid your bill within 60 days of billing, fees are due and payable in full from you; otherwise we will bill it to your credit card, upon seven business days. We will not bill your credit card without informing you.
6. _____ All parents must initial next to the following policies to signify that they have read, understood and agreed to the above financial policy for payments of professional fees.
- a. _____ I/We understand that if I/we have any questions or concerns about the Financial Agreement, that it is my/our responsibility to seek understanding so that I fully comply with all the policies.
- b. _____ No person may pick up my child unless Innovative Therapy Services has the person's authorized signature on file.
- c. _____ I/We have read the Innovative Therapy Services handbook.
- d. _____ I/We understand that I /we will be charged the full fee if I fail to notify an absence prior to 24 hours.
- e. _____ I/We understand that I must pay the first half of my child's re-evaluation report and the final half upon the completion of report. I will not receive the report, unless I have paid **all portions**.
- f. _____ I/We understand that I/we are going to notify Innovative Therapy Services of vacation plans prior to my child's enrollment, so that an agreement can be reached between the parents and Innovative Therapy Services to hold my child's spot, otherwise I/we will be charged for the full fee.

Parent Signature: _____

Date: _____

Name (Please Print): _____