Innovative Therapy Services

Pediatric Speech-Language Services

Expect the best in learning Speech, Language and Social Skills

1090 Homestead Road
Santa Clara, CA 95050
Ph (408) 241-2229
Fax (408 241-3156
www.pediatricspeech.com

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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Toddler 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?

☐ Yes ☐ No Does your child imitate facial expressions?

☐ Yes ☐ No Does your child imitate speech sounds?

☐ Yes ☐ No Does your child imitate behaviors he or she observed at an earlier time (not immediately following the model)?

☐ Yes ☐ No Can your child point to common objects when you name them (e.g. using picture books)?

☐ Yes ☐ No Does your child understand you when you talk to him or her?

☐ Yes ☐ No Does your child answer simple questions?

☐ Yes ☐ No Does your child respond to simple commands (e.g. “Get your cup”)?

☐ Yes ☐ No Does your child maintain eye contact with you?

☐ Yes ☐ No Does your child smile?

☐ Yes ☐ No Does your child play well with others?

☐ Yes ☐ No Does your child seem to understand the functions of objects (e.g. a cup Is for drinking, a brush is for brushing hair)?

☐ Yes ☐ No Does your child ask questions?

With whom does your child spend a majority of the day?

What kinds of play activities does your child engage in?

Describe a typical day (include details):

Does the child have difficulty running, walking, or participating in other activities that require small or large muscle coordination?

Are there or have there ever been any feeding problems (e.g. problems with sucking, swallowing, drooling, chewing)? If yes, please describe.

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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

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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:_____

SANTA CLARA COUNTY EARLY START PROGRAM

ASSESSMENT PLAN--ESP

The use and distribution of this form is limited to employees of the public agencies associated with the *Santa Clara County Early Start Program (ESP)*

❒ Initial Referral ❒ 6-month Review ❒ Annual Review ❒ Other Review _____

To Parent or Guardian of _____ _____ Date _____

Early Start Program (ESP) Site _____ School District of Residence _____

-Language to be used for assessment _____

The above named child has been referred and/or recommended for an assessment by the following individual(s):

❑ Physician / Nurse/ PHN ❒ Audiologist ☒ Parent ❒ Childcare Provider ❒ Social Worker

☑ Speech/Language Pathologist ❑ Occupational Therapist ❑ Physical Therapist ☒ Early Intervention Teacher ❒ Other

The reason for the referral for assessment is _____

_____

Based on the recommendations of the Early Start Program's evaluation team and your input, the Early Start Program (ESP) proposes the following assessment in order to meet your child's individual needs. The assessment will be conducted by qualified staff utilizing parent/staff interview, review of records or reports, play assessment and/or observation. When appropriate, a suitable interpreter of your family's primary language may be used. You may receive a copy of the assessment findings, upon request, prior to the Individualized Family Service Plan (IFSP) Team meeting. You will be asked to participate in a meeting of the IFSP Team following completion of the evaluation or assessment. The results of this assessment may be a recommendation for early intervention services or maintenance or change of the current early intervention service(s). An IFSP is developed together with the family and will not be implemented without consent of the parent or guardian. All information and assessment results will be kept confidential. **Children birth-three must be assessed in *all* areas of development.**

Family Priorities, Concerns and Resources *(Voluntary on the part of the parent)* _____ (Parent--*initial for consent*)

Physical Development

Purpose: Tools in this area measure how well your child coordinates body movements in small (fine motor) and large (gross motor) muscle activities as well as the status of your child's health including vision and hearing. **Tools may include**, but are not limited to: review of medical and/or therapy reports; *Denver Developmental Profile (Denver); Alpern Boll Developmental Profile; Vineland, Hawaii Early Learning Profile (HELP); Carolina Curriculum for Handicapped Infants and Toddlers (Carolina); Battelle Developmental Inventory (BDI); Umansky Assessment Programming Guide (Umansky); Hear Kit; Functional Vision Assessment (various); Oregon Project for visually Impaired or hearing impaired preschoolers; Peabody Motor; Desired Results Developmental Profile-revised (DRDP-r) or DRDP-Access (DR-Access); Ages & Stages Questionnaire (ASQ).*

Others: _____

Adaptive/Self Help Development

Purpose: These tools measure how your child takes care of her/himself including sleeping, eating, dressing and toileting etc. **Tools may include**, but are not limited to: *Denver; Peabody-Sensory; Alpern Boll; Vineland, HELP, Carolina; BDI; Umansky, Oregon Project, DRDP-r or DR-Access.*

Others: _____

Cognitive Development

Purpose: These tools measure how responsive your child is to different environments and how your child solves problems. **Tools may include**, but are not limited to: *Denver; Alpern Boll; Vineland; HELP; Carolina; BDI; Umansky; Oregon Project; DRDP-r or DR-Access.*

Others: _____

Communication Development

Purpose: These tools measure your child's ability to understand, relate to and use language and speech clearly and appropriately. **Tools may include**, but are not limited to: a language sample; *Denver, Alpern Boll, Vineland, HELP, Carolina, BDI, Umansky, Oregon Project; Preschool Language Scale (PLS); Receptive-Expressive Emergent Language Test (REEL); Rosetti Infant Language Scale, DRDP-r or DR-Access.*

Others: _____

Social/Emotional Development

Purpose: These instruments will indicate how an individual cope with situations, gets along with other people, and takes care of herself/himself. **Tools may include**, but are not limited to: Interview; *Denver; Alpern Boll; Vineland; HELP, Carolina; BDII; Umansky, Oregon Project; ASQ-SE; DRDP-r or DR-Access.*

Others: _____

The professional(s) involved in the individual assessment plan above may include:

-Early Intervention Teacher ☒-Occupational Therapist ☒-Psychologist ☒- Nurse ❒- Audiologist

☒-Speech/Language Pathologist ☒-Physical Therapist ☒Social Worker ❒-Other _____

If you have any questions about the above Assessment Plan, please call your service coordinator:

Name & Title _____ Phone 408-241-2229

THIS FORM MUST BE SIGNED BEFORE ASSESSMENT CAN BEGIN

Please check the following items, as appropriate.

❒ I give informed consent for my child (named above) to be assessed according to this Assessment Plan.

❒ I request that these independent assessments be considered: _____

❒ I deny consent to conduct the assessment described above.

❒ I have received a copy of my Parents' Rights and Procedural Safeguards.

Parent/Guardian/ Surrogate Signature _____ Date ___ / ____ / ____

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PARENT HANDBOOK SARC

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, 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 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 schedule 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 to disrupt your child's therapy as that is our number one priority.

Cancellation

1. **Client cancellation policies**: 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 cancelation.** If our therapist cancels sessions we will attempt to schedule a makeup within two weeks of the cancelled session.
3. Makeups provided for any session cancelled 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 makeup cancelations by any therapist at the clients best available times. Please note if we try for 4 months and cannot successfully give you a makeup you will be issued a refund
5. **All cancelled sessions are billed:** It is the client's' discretion to makeup the cancelled session. Clients are charged for all cancelled 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 written note/excuse for medical emergency, etc. No Shows are be billed as our regular therapy fees. **Clients that we bill insurance their insurance are not 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.**
7. 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. **Termination of Services due to frequent cancellations:** Clients must maintain consistent attendance. If clients cancel more than 4 sessions in a quarter, 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.
9. **Therapist Cancelations** if and when therapist cancel, as a courtesy to the clients we have to schedule a makeup ASAP with the therapist on her available times. Work with the therapists to immediately give you times available. Email the parent immediately to confirm the time works. When contacting the parent, please state that we will provide a makeup ASAP within two weeks.

Plan of Care Discharge from Innovative Therapy Services Protocol

Upon reviewing California licensing guidelines, ASHA guidelines, and other best practice guidelines, Innovative Services has established the following clinic guideline for discharge of care in the clinic. According to ASHA and State License guidelines, services should be terminated if "The individual's cognitive, communication, and/or swallowing skills adversely impact performance, health, and/or safety." Based on these principles, clinicians should discharge clients from treatment if:

Criteria for Discharge of Care for Mild to Moderate

a. Treatment no longer provides measurable benefit (from ASHA). A "measurable benefit" refers to a positive outcome that can be quantified, tracked, and demonstrably shown to improve the child's functional and social communication. If there is no improvement in functional and social communication outcomes after 3 months of treatment, a meeting will be scheduled to discuss ways to better support the child. The goals may be modified with consent from the family. However, if there is no progress in functional communication skills after 6 months of treatment, such as using AAC to request needs and desires or verbally requesting needs and desires, a plan for discharge and referral to other supportive services will be established.
b. The speech, language, communication, and/or feeding and swallowing disorder now falls within normal limits or matches the individual's ability. A meeting will be arranged to discuss the discharge plan of care.
c. The individual has achieved the treatment goals and objectives. If the child has met all treatment goals and is performing within normal limits according to treatment criteria, the frequency of care will generally be reduced gradually until discharge, accompanied by follow-up and community support.
d. The individual's speech, language, cognitive, communication, and/or feeding and swallowing skills no longer negatively affect their performance, health, and/or safety.
e. Parents are not involved in treatment and are not supporting the home program provided. A meeting should be arranged to understand and set forth the plan for participation. If after 3 months of post meeting with the family, the parents are still not participating, a discharge of care plan should be established.
f. The individual using an AAC system has reached optimal communication across various environments and with different communication partners.
g. The individual meets nutrition and hydration needs either orally or through alternative means (e.g., percutaneous endoscopic gastrostomy), and demonstrates adequate swallowing function to manage oral and pharyngeal saliva accumulations.

Other considerations in Determining Discharge from our Innovative Therapy Services

- After a year of treatment and multiple attempted modifications, if the treatment no longer yields measurable benefits, a meeting will be scheduled to discuss the discharge plan of care.
    - For severe behaviors like hitting, biting, or property damage, we will meet with the family and the child's behavior team for further support. If the team's recommendations are within our licensed practice, they will be

applied. If these suggestions do not work, a discharge plan will be made. If the behavior endangers clinic staff, treatment will stop, and the child will be placed on the waitlist until they can safely resume services.

- Behaviors affecting functional speech and language outcomes, including eloping, lack of interest, fatigue, or an overloaded treatment schedule, will initiate a meeting to discuss discharge and re-enrollment when the child's schedule becomes more flexible.

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 the person 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.**
   10, 15, 20, 25+ minutes late pick up billed at $64.50 30+ -- 45 minutes late pick up is billed at $93.25, 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.

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 comes 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 encouragements.

Support and Procedures within Group Settings

As this clinic does conduct various Social Skill programs (i.e. All for 3's and PLSS Summer Camp), we use the following procedures for support and discipline of arrant behaviors. They are listed below:

1. If a client is disruptive in the group, he or she will be accompanied by a therapist to a separate room to de-compress, debrief and gain control in order to return to the group.

2. The client is given 3 opportunities to decompress, debrief and gain control by leaving the setting. If the student has to be removed more than 2 times from the social structure, the student will be accompanied by a communication partner to continue social interaction for about 10 minutes and then given a choice to continue with peers or go home.

3. If client continues to be disruptive, privileges such as choices of activities, prize etc., will be taken and the student will have opportunity to debrief and redeem back some of the privileges.

4. If the client hits, scratches or spits at members of the social group, the client will incur the highest level of discipline in the form of going home.

5. If a client continues to consistently display physical aggression to students and staff, we will refer the family to behavioral support. Extreme cases require that we ask that the client discontinue services in the group setting until behaviors are abated.

Rights and Protections

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.

2. ***Physical abuse*** - Frustrated or angry parent or care giver 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.
3. ***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.
4. ***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.
5. ***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.

Holiday Schedules

During the major holidays (as noted below), ITS shifts the regular therapy schedule to holiday office hours during the holiday week. Parents will be provided with specified adjusted office hours, and client schedule changes in advance. Please take note: parents are responsible for providing advanced *(at least 2 weeks)* notice of planned vacations, so we are able to schedule and provide makeups in advance. All clients will be billed in accordance to therapy slots provided, with no exceptions.

- **New Year's Eve (December 31st)**
- **New Year's Day (January 1st)**
- **Independence Day (July 4th)**
- **Thanksgiving Day (Fourth Thursday in November).**
- **Christmas Eve and Christmas Day (December 24th and 25th)**

Withdrawal and Termination

At Innovative Therapy Services, we are required two weeks' notice for termination of therapy. If you fail to provide us two weeks' notice, you will be responsible for paying scheduled sessions. We also reserve the right to discontinue therapy services at any time. If you have any questions, please contact us at (408) 241-2229.

PARENT HANDBOOK RECEIPT

Please sign and return bottom portion of form to acknowledge receipt of your parent handbook.

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

Signature **Date**

Print Name