

Santa Rosa Scottish Rite Children's Language and Learning Center
625 Acacia Lane
Santa Rosa, CA 95409-3402
Telephone (707) 539-3003
Fax (707) 539-5905
www.srclc.com

APPLICATION FOR SERVICES

We appreciate your interest in our speech/language/learning programs. At your request, please find enclosed the required forms necessary to initiate services for your child. Complete the application in full, enclose previous speech therapy evaluations, Individual Education Plans (IEPs) and progress reports, and then mail all of them to us or you may fax them. The services provided by the Santa Rosa Scottish Rite Children's Language and Learning Center are free of charge. The programs are supported entirely by contributions from clients, friends and volunteers.

Please complete below

Client's name: _____

Date of birth: _____

Parents' names: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: H: _____ W: _____ C: _____

Parent signature (required): _____

Parent signature (required): _____

Date: _____

Contributions are deductible on Federal and State Income Tax under our Federal ID # 94-6078728

CONSENT TO USE AND DISCLOSE INFORMATION FOR TREATMENT AND HEALTH CARE FOR YOUR CHILD

The Health Insurance Portability and Accountability Act (HIPAA), which became Federal law on April 14, 2003, allows us to use or disclose Protected Health Information on your child, from your records, in order to provide treatment to your child, and for other professional activities (known as “health care operations”). Nevertheless, we ask your consent in order to make this permission explicit.

The Notice of Privacy Practices, which you agreed to, and were given a copy of the Notice, described the disclosures in more detail.

You have the right to review the Notice of Privacy Practices before signing this Consent. We reserve the right to change the terms of our Notice of Privacy Practices at any time and will inform you of such change. You have the right to object or withdraw at any time from this Consent. If you refuse to sign this Consent form, we will be required to review your request as to whether we can then continue with the evaluation or therapy program for your child.

You have the right to ask us to restrict the use and disclosure of your child’s protected health information that otherwise would be disclosed for treatment. This means that you may ask us not to use or disclose any part of your child’s protected health information for any purpose.

You may revoke this consent at any time by giving written notification. Such revocation will not effect any action taken in reliance on the consent prior to the notification.

This consent is voluntary. You may refuse to sign it. However, we are permitted to refuse therapy or evaluation speech and language services if this consent is not granted, or if the consent is later revoked by you.

“I hereby consent to the use or disclosure of my child’s Protected Health Information as specified above”.

Date: _____ Child’s name: _____

Signature of Parent or Other Responsible Party: _____

NOTICE OF PRIVACY PRACTICES

To: Parent, Guardian or Custodian of _____

Please review this important notice and retain a copy for your personal reference. The protection and privacy of your child's personal healthcare information is very important to us. A new Federal Law titled: The HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) went into effect on April 14, 2003.

It required all Health Providers to take certain measures designed to protect the privacy of your child's records. In compliance with the provisions of the Act, it is our legal duty to safeguard your child's protected healthcare information. One of the requirements in the Act is for us to notify you of these privacy measures and to obtain for our files your signed acknowledgment of having received this notice.

This notice describes how our speech-language pathologists, therapists, volunteers and other staff members may use and disclose data on your child's treatment only when required by law, or in case of referral, to other specialists or physicians. The Santa Rosa Scottish Rite Children's Language and Learning Center does not do any billing for services given by any child to any outside agency. It, therefore, does not disclose any information regarding your child's treatment by doing so. Your child's records, when not being used, are kept in a locked secured cabinet accessible by authorized personnel only. Records are only released, when deemed necessary, to any third party only with your signed written consent. Your speech-language pathologist will give you copies of all reports pertaining to your child upon request. It is our preference that you keep them, and that you provide copies of them, as appropriate, and when you deem essential, to other parties for your child's treatment.

If you have any questions or concerns about this Notice, or any complaints about these Privacy Practices, or would like to know how to file a formal complaint, please contact our ***Privacy Officer and Executive Director, John M. Samples, Ph.D. at 539-3003.***

I acknowledge receipt of this Notice:

Child's name: _____ Parent or Guardian name: _____

Parent or Other Responsible Party's Signature: _____

Date: _____

Policies

Emergency Policy

In case of an emergency, the staff and volunteers are empowered with the responsibility to protect the life and welfare of your child. Neither the staff and volunteers nor the Center may be held accountable for damages to said child if it is determined that the staff member(s) and volunteer(s) acted in a responsible manner.

I understand the policy concerning emergencies.

Parents' signatures: _____ Date: _____

Supervision Policy

Your child will be supervised by a number of staff members and volunteers while at the Center. These include the receptionist/secretary, the speech-language pathologists and volunteers as assigned by the Executive Director. Your child is expected to comply with all directions and requests made by the staff members and volunteers. If your child is unable and/or unwilling to comply, we will have to consider terminating therapy.

I understand the policy concerning supervision.

Parents' signatures: _____ Date: _____

Illness Policy

If you, or your child, show any sign of a cold, flu, cough, fever, or respiratory disease, DO NOT come to the Center. Please use good judgment. Call 24 hours in advance, if possible. The therapists and volunteers reserve the right to cancel your child's speech therapy when you arrive, if in their judgment, you or your child is not well enough to participate in therapy. This, also, applies to you as parents since we normally request that you stay and observe or participate in the therapy sessions.

I understand the policy concerning illness.

Parents' signatures: _____ Date: _____

Policies

Attendance

Regular and prompt attendance at therapy sessions is essential. Inconsistent attendance hinders your child’s progress. We must restrict services to only those children who attend regularly. Your child is expected to attend therapy sessions on a regular basis. If your child is unable and/or unwilling to attend, we will have to consider terminating therapy. Cancellations MUST be called into the Center 24 hours in advance of your child’s therapy time.

I understand the policy concerning attendance.

Parents’ signatures: _____ Date: _____

Photography/Videotape Permission

From time to time, as a non-profit organization, and on special occasions, we take photographs and/or prepare videotapes of children and parents receiving services at our Center. The photographs/videotapes may be used as part of educational/professional presentations to the public and other interested groups in order to describe the services of our Center, and also, for professional research studies and public relation purposes. We appreciate your indicating below that you give us such permission.

I hereby (DO) (DO NOT) authorize Santa Rosa Scottish Rite Children’s Language and Learning Center to photograph and/or videotape, publicly display or publish photographs/videotapes concerning:

(Child’s name in full)

Parents’ signatures: _____ Date: _____

History Forms

Family

Tell us about your family. Are you living together, what are your occupations, are there other children in the family, and what are their ages? What is your first language? Are there other languages spoken? Do other family members have language or learning problems?

Previous Evaluations

Are there other evaluations and/or progress reports completed on your child within the last 6 months? Please provide copies of these reports. What are the primary and secondary diagnoses, if known, and who made the diagnoses?

Medical

Please list any important medical history that relate to the speech, language and learning problems. Include length of pregnancy, birth weight, medications, major illnesses, allergies, surgeries, ear infections, and hearing acuity.

Educational

Please list your child's school, teacher's name, speech-language pathologist, resource teacher's name, special day class teacher's name, and grade level. What special assistance or help is given at school? What is your child's learning style?

Other

Describe your child's behavior and personality, such as temper tantrums, shyness, overactive, ADHD, ADD, or spectrum disorders. What types of discipline are most effective, and do you see behavior problems related to your child's speech, language, cognitive, or reading development. What other contributing factors are present, such as emotion factors, brain injury, or hearing?

Please include anything else you feel we need to know:

