



HELP ME SPEAK, LLC
Barbara A Taylor, M.S., CCC-SLP
& Associates
2500 Wallington Way; Suite 103
Marriottsville, MD 21104
410-442-9791

Dear Client,

Welcome to Help Me Speak! We look forward to meeting you and your child at the initial evaluation.

We've scheduled an evaluation session on (**Monday/Tuesday/Wednesday/Thursday/Friday**), _____ (**date**) at _____ (**time**). Also, please complete the enclosed forms and send or bring the following information:

- All previous evaluation reports by physicians, therapists, & teachers within the past 6 months to one year
- A list of all medications/supplements that your child takes regularly, if any.
- Your child's IEP including hours of service for SLP, OT, special education, &/or PT
- The names, addresses and phone numbers of any therapists and doctors with whom you desire me to share information

Return the above information and enclosed forms to Help Me Speak at the address above so that we may receive them *prior to* the evaluation day. You may also fax them to us at 410-442-9783. If you are unable to complete these forms and compile this information, please bring all of the above with you.

When you come to the evaluation, please bring the following items that your child typically enjoys*:

- The dish, cup & utensils that your child normally uses
- A **liquid** that your child typically drinks such as fruit juice or milk
- A **semi-solid** such as applesauce, yogurt or pudding
- A **soft solid** such as a banana, canned fruit, or *cubed* cheese
- A **hard solid** such as carrot sticks or apple wedges
- A **crunchy solid** such as pretzel rods, tortilla chips
- A **chewy solid** such as fruit snacks, a bagel, or meat

*If your child does not enjoy a type of food listed, please bring an example of it, which you think your child *may* try.

Please keep in mind that careful planning and preparation (including record review) goes into your child's evaluation to determine his/her needs and strengths.

In the event that you need to cancel your child's *evaluation*, **48-hour notice is required**. There is a **\$50.00 fee** for less than 48-hour cancellation notice, for last minute/no-shows, or for rescheduling of >1 time. We regret that we must implement this policy, but it has become necessary. Exceptions may be made to this policy in rare, extenuating circumstances with the permission of the owner of Help Me Speak. Please read and sign the attached letter. The fee will be charged to the credit card #, which you provided to our office upon registration.

If your child or your family exhibits any of the following symptoms within the 24 hours prior to his/her appointment, please call to cancel or reschedule your therapy session:

- a temperature of 99.0 or above
- sore/strep throat (&/or severely red throat)
- vomiting
- coughing
- a new contagious infection for which he/she has not started antibiotics (sinus infection, pink eye, flu, cold, severe coughing, etc.)
- discolored mucous (yellow or green)
- influenza
- any other contagious symptom

In the event that you need to cancel your child's **therapy session**, at least **24-hour notice is required**. Please keep in mind that careful planning and preparation goes into your child's therapy session to maximize progress and potential. Also, there is a waiting list for current slots. **Any session not cancelled with 24 hour advance notice or a no show will be charged at the full session fee**. Please read and sign the attached letter for more information on make-up sessions. The fee for missed appointments must be collected prior to (or at) your next scheduled appointment.

You are financially responsible for any breakage or damage by your child to any item (toys, therapy equipment/tools, office space, etc.) within this office. Payment for any items damaged will be required prior to (or at) your next therapy session.

Directions to our *new* Help Me Speak, LLC office are attached. We now have a waiting area and invite you to **arrive 15 minutes early** so that you will have time to review our policies. We look forward to meeting you and your child. Please call us with any questions at (410) 442-9791.

Sincerely,

Barbara

Barbara A Taylor, M.S., CCC-SLP
Speech-Language Pathologist
Owner/Director, HELP ME SPEAK, LLC



HELP ME SPEAK, LLC
Barbara A Taylor, SLP
& Associates
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Directions to the *New* HELP ME SPEAK office location:

From Columbia Mall area/Rt 108:

1. take Harper's Farm Rd across Rt 108-→ it becomes Homewood Rd.
2. continue on Homewood Rd until you reach the circle/roundabout in the road
3. go 1/4 to the right and turn right onto Folley Quarter Rd
4. go to end of Folley Quarter Rd
5. turn left onto Rt 144
6. continue on Rt 144 until Marriottsville Rd on right
7. turn RIGHT onto Marriottsville Rd
8. cross Rt 40, cross over I-70
9. Make a RIGHT at the 1st traffic light→ Warwick Way (just past blue silo bldgs)
10. Make an immediate RIGHT to the professional buildings on **Wallington Way**
11. We are on the **LEFT** (the building up the hill/behind the blue silos)
12. Park on your LEFT in any of the available spaces
13. Our suite is # 103

From Rt 32:

1. take Rt 32 West to I-70
2. take I-70 East (very short distance)
3. take the Rt 40 EXIT
4. turn LEFT at the light for Marriottsville Rd
5. cross over I-70
6. continue as in #9 above

From Rt 29:

1. Rt 29 North to I-70 West (take either the left or right hand exits from Rt29)
2. I-70 West to the first exit at Marriottsville Rd.
3. There is only ONE exit. On the exit ramp, bear Right onto Marriottsville Rd.
4. Continue as in #9 above

From points west:

1. I-70 East to Rt 40 EXIT
2. Turn LEFT at the light for Marriottsville Rd
3. Cross over I-70
4. Continue as in #9 above

Rev 7/09
Barbara.taylor@helpmespeak.com
410-442-9791

Help Me Speak LLC
www.helpmespeak.com

From points east:

1. 695 West to I-70 West
2. I-70 West, past Rt 29 exits
3. To Marriottsville Rd exit
4. There is only ONE exit. On the exit ramp, bear Right onto Marriottsville Rd.
5. Continue as in #9 above

From points north of Marriottsville Rd (Owings Mills, Reisterstown, etc.)

1. Drive to Marriottsville Rd & go South
2. Cross over Rt 99 at the light, continue south
3. At the next light, turn Left onto Warwick Way (brick building w/silos faces road)
4. Continue as in #10 above

I _____, understand that the fee for less than 24-hour cancellation notice & for no-show appointments is \$105. The fee for missed appointments must be collected prior to (or at) my child's next scheduled appointment.

You are financially responsible for any breakage or damage by your child to any item (toys, therapy equipment/tools, office space, etc.) within this office. Payment for any items damaged will be required prior to (or at) your next therapy session.

I accept full financial responsibility for any damage by my child, _____, to any therapy/office item. Payment for items damaged is required prior to (or at) my child's next scheduled therapy session.

Initials

Date

Evaluation Agreement

I, _____, understand that the rate for this evaluation (speech/oral-motor/eating language other: _____) is \$_____/hour which is *due at the time of service to Help Me Speak LLC*. Payment may be made by check, cash, or credit card (Visa, MC, Discover). This fee is non-negotiable and non-refundable after the service is rendered. Failure to pay at the time of service will result in a \$25 *per week* late charge.

If requested, Help Me Speak will provide you with an invoice for each visit and a monthly billing statement for your records. It will be your responsibility to pursue insurance reimbursement if these services are covered. Help Me Speak does not accept or bill your insurance carrier.

The parents of the client understand that Help Me Speak LLC will make every effort to ensure a complete and thorough evaluation in the areas requested by the parents. Certain evaluation techniques require cooperation and participation from the client to accurately assess the client's skills. Parents understand that Help Me Speak LLC will not be held responsible for a fully completed evaluation if the client refuses to cooperate during the evaluation session(s) even after all reasonable attempts have been made to engage him/her. In such cases, either Help Me Speak LLC or the parent has the right to end the evaluation session early as needed and to reschedule the remainder for a follow-up session.

Help Me Speak LLC speech-language pathologists must abide by ethical practices from their Professional Boards that forbid the guarantee of any specific evaluation results for any client.

By signing below, I acknowledge that I have read and understand this evaluation agreement and will fully abide by all of the terms stated above and am consenting to treatment.

Initial	Date	Relationship to Client
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Therapy Agreement

I, _____, understand that the rate for a 50 minute therapy session is \$_____ which is *due at the time of service to Help Me Speak LLC*. Payment may be made by check, cash, or credit card (Visa, MC, Discover). This fee is non-negotiable and non-refundable after the service is rendered. Failure to pay at the time of service will result in a \$10 *per week* late charge.

The parents of the client understand that the therapy session(s) will be planned and will be individualized in accordance with the results of his/her child's evaluation results. Therapy sessions utilize a variety of techniques and modalities (which may include structured oral motor hierarchies, stretches, PROMPT, Kaufman cards, etc.) as appropriate to each client's needs, which are selected by the speech-language pathologist (SLP). The parents and the client understand that homework assignments are an important component of the total therapy program and agree to participate as prescribed by the SLP. Exercises and tasks given for homework will be reviewed with the client, as appropriate, and with his/her parent. Help Me Speak LLC aims to give homework elements that are emerging during therapy sessions and that will not elicit frustration for either the client or the parent during practice. Homework programs are typically prescribed 1-3x/day for 3-5x/week. The parent and the client, as appropriate, understand the importance of consistent weekly participation in the recommended homework plan. Lack of participation in or decreased consistency with the homework plan by the client

and parents may impact the client's overall amount and rate of progress. Help Me Speak LLC is not liable for lack of progress, a reduced rate of progress, or a reduced amount of progress if the client and parents have not been fully participating with the homework plan.

Help Me Speak LLC speech-language pathologists must abide by ethical practices from their Professional Boards that forbid the guarantee of any specific progress results for any client.

By signing below, I acknowledge that I have read and understand this therapy agreement, will fully abide by all of the terms stated above and am consenting to therapy.

Initials Date Relationship to Client

Therapy Schedule Change or Cancellation

If my child/ren need to change his/her/their therapy session day or time, I will give Help Me Speak, LLC at least 2 weeks' notice of this change. If we decide to cease therapy services, we will notify Help Me Speak, LLC at least 2 weeks in advance.

Initials Date Relationship to Client

Check Return Policy:

There will be a \$25.00 charge for all returned checks for non-sufficient funds. The sum of the original check plus the \$25.00 NSF charge must be received prior to any further visits.

By signing you are agreeing to the above terms.

Client's Name Signature/Responsible Party

Authorization to use Voice, Image and Likeness

I hereby authorize my child/children to be videotaped, photographed, and/or audio taped during any therapy activity (evaluation, session, group, class or event) at Help Me Speak LLC. As a parent of a child participating in any therapy at Help Me Speak LLC, I hereby agree that Help Me Speak LLC may make video, photo, &/or audio recordings of my child's voice, image and/or likeness. I further understand that Help Me Speak LLC preserves such videotapes, photos, and audio tapes for its own use for the benefit of educational training, marketing and advertising. I acknowledge that the rights to any such recording belong solely to Help Me Speak LLC and I make no claim to any rights in such recordings. To the extent necessary, I assign any copyright or other right which I may have in my child's action as captured on such video and audio tape fully, completely and without royalty to Help Me Speak LLC.

Parent/Guardian's Signature

Date

RELEASE OF INFORMATION

Client's name: _____

I give my permission for Help Me Speak LLC to release information to and to receive information regarding my child's speech-language assessment and/or treatment results from the following individuals/organizations:

Name

Address/Phone Number

Name

Address/Phone Number

Name

Address/Phone Number

Signature

Relationship to client

Date

Client Registration

Date: _____

Client's Name: _____ Date of Birth: _____

Social Security Number: _____ Responsible Party: _____

(relationship): _____

Address: _____ Parents' Names: mother _____

_____ father _____

_____ email: _____

Mother

email: _____

Father

Home Phone: _____ Mother's Cell Phone: _____

Father's Cell Phone: _____

Occupation: Mother _____ Occupation: Father: _____

Mother's Work Phone: _____ Father's Work Phone: _____

Mother's Age: _____ Father's Age: _____

Mother's Employer/Address: _____ Father's Employer/Address: _____

Primary Care Physician/Address/Phone: _____

Diagnosis (Reason for Treatment): _____ Onset Date: _____

I certify that the above information is true. I will notify Help Me Speak LLC of any changes to the above information.

Print Client's Name

Client's Signature or Responsible Party

Waiting Room Policy

Please refrain from eating messy foods and drinking messy beverages in our waiting room. Any spills are your responsibility and you will be charged accordingly. Remember, this office space is *brand new*. Water and dry snacks only are allowed in the waiting room. Also, please **NO PEANUT** or **NUT** products in the waiting room due to potential allergies of other clients.

Thank you for your cooperation and understanding.

I understand & promise to abide by the above waiting room policy.

Parent's Signature

Date

Drop Off Policy

If your child does *not* exhibit separation anxiety and your child's SLP is *in agreement* that you do *not* have to be present during the entire therapy session, then you may drop off your child for therapy. Your child's session lasts for **50 minutes**. You must return to Help Me Speak **10 minutes prior** to the end of your child's therapy session. It is important that you are on time!

(e.g. return at 8:40 if the session starts at 8:00 or return at 9:10 if the session starts at 8:30)

Your child's SLP will use *these last 5-10 of therapy to review the session and to teach you* any new information. Your child's SLP needs the 10 minutes in between sessions to clean up, set up and take care of any other related business.

Help Me Speak, LLC and your child's SLP are not responsible or liable for your child and it is unsafe for any child to be unattended after his/her session is completed. We require that a parent or guardian call 410-442-9791, if he/she suspects that he/she will be late picking up the participant. This phone call is only to reassure the child. If for any reason, tardiness persists, then your child's artist/therapist will have to discuss it with you. A fee may be charged at that time. If for any reason, tardiness persists, then your child's SLP will have to discuss it with you. Thank you in advance for your promptness.

I understand & promise to abide by the above Drop Off Policy.

Parent's Signature

Date

Medical Attention

I, _____, agree that in the event _____, client is involved in an incident that requires medical attention, the undersigned will be responsible for making the all the decisions related to all medical and survival procedures for the client while the client is enrolled in the program, including, but not limited to, the decisions about medical care, the administration of drugs, and the performance of any and all life sustaining procedures. The undersigned further agrees to make any and all arrangements for the client's transportation and admittance to any hospital, health center, or medical clinic in the event of an emergency situation involving the client. In the event that the parent or emergency contact cannot be reached during the medical emergency, the undersigned gives Help Me Speak, LLC permission to make decisions regarding any and all medical and survival procedures for the client. The undersigned agrees that Help Me Speak, LLC, its owners, employees, contractors, volunteers and staff will not be held responsible for any accident or losses, however caused.

Release of Liability

The undersigned waives any and all claims or actions that may arise against Help Me Speak, LLC, as well as its owners, employees, contractors, volunteers and staff as a result of any injury, loss, theft, or damage to any such person, including and without limitations, personal, bodily or mental injury, economic loss or any damage to the client. The undersigned agrees to defend, indemnify and hold Help Me Speak, LLC harmless against any claims (including reasonable attorneys' fees) arising out or resulting from acts or omissions of the client or me or the breach by me or the participant of this Agreement.

I am the parent(s) or legal guardian(s) of the above referenced client and I hereby certify that I have read and understand this entire Agreement and agree to and accept its terms and conditions. I further agree that the client will abide by all rules and policies of Help Me Speak, LLC, which are subject to change and which, in the opinion of Help Me Speak, LLC, are deemed necessary and reasonable for the best interests of the clients of Help Me Speak, sessions. Finally, no client will be admitted to Help Me Speak sessions without this Agreement form completed in its entirety.

Signature of parent or legal guardian

Date