LKS & ASSOCIATES
Speech and Occupational Therapy

12121 Wilshire Boulevard, Suite 314 Los Angeles, CA 90025 / 310-739-9337 / admin@lksandassociates.com / www.lksandassociates.com

PATIENT REGISTRATION, ACKNOWLEDGEMENT, AND AGREEMENT

Welcome to LKS & Associates. We are delighted that you have chosen us to be your therapy provider. This Patient Registration form must be completed, signed and received by LKS & Associates before any therapy services are provided. The Patient Registration form contains:

1. Patient Information
2. Patient Policies
3. Credit Card Authorization
4. Patient Privacy Notice
5. Patient Acknowledgement

1. PATIENT INFORMATION

PATIENT INFORMATION	
Name of patient:	Nickname:
Date of birth:	Age:
Street address:	State:
City:	Zip:
Home phone:	
FAMILY INFORMATION	
Parent/Guardian 1 name:	Parent/Guardian 2 name:
Parent/Guardian 1 address:	Parent/Guardian 2 address:
Parent/Guardian 1 cell phone:	Parent/Guardian 2 cell phone:
Parent/Guardian 1 home phone:	Parent/Guardian 2 home phone:
Parent/Guardian 1 work phone:	Parent/Guardian 2 work phone:
Parent/Guardian 1 email:	Parent/Guardian 2 email:
Parent/Guardian 1 occupation:	Parent/Guardian 2 occupation:
Does Parent/Guardian 1 have legal custody of Patient: yes no	Does Parent/Guardian 2 have legal custody of Patient: yes no
Does Patient live with Parent/Guardian 1? yes no	Does Patient live with Parent/Guardian 2? yes no
MEDICAL PROFESSIONALS	
Primary Doctor Name:	Doctor Phone:

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Dentist Name:	Dentist Phone:
Orthodontist Name:	Orthodontist Phone:
CURRENT THERAPY	
Type of therapy: Frequency: Therapist name: Therapist phone:	Type of therapy: Frequency: Therapist name: Therapist phone:
Type of therapy: Frequency: Therapist name: Therapist phone:	Type of therapy: Frequency: Therapist name: Therapist phone:
CURRENT SCHOOL	
School name:	
Grade level:	
Days attended:	
Times attended:	
FAVORITES	
Favorite Toys:	
Favorite Foods:	
Favorite Drinks:	
Favorite People:	
FOOD ALLERGIES	

Please list any food allergies:

PATIENT GOALS

Please detail your goals while attending Speech Therapy:

2. PATIENT POLICIES

Payment
We invoice monthly on the last day of each month and will forward your invoice via electronic mail. Payment via **cash, check, Venmo** (lisa-klein-14), or **credit card** is due within 10 days of receipt of the invoice. If paying via cash, Venmo, or check, your credit card information will still be requested (see below) and kept on file. If payment is not received by the 10th of the month, your credit card will be charged on the 11th day and will include the additional 3.5% processing fee.

Reports
Re-evaluation, yearly progress reports, program plan updates and/or annual reviews with goals and objectives are not included in your current rates. We will charge an additional hourly rate of $190 per hour per assessment and preparation of materials requested.

Lateness
If a client is late, the client will only receive therapy for the time slot they were assigned. For example, if a client arrives at 4:15 pm for a 4:00 pm 30 minute session, the session will still end at 4:30 pm without any adjustment to the fee. Please be on time for your session to assist in maximum progress gains.

No Drop-Offs
The office is not a drop off facility. The parent/guardian is required to be present in the office during the entire duration of the child's therapy session.

Traveling Fee
If the traveling time exceeds 10 minutes for a co-treatment or school observation, an additional fee of $25 per 10 minutes for travel time will be added to the total cost of the session.

Email
You give permission for LKS & Associates to contact you through electronic mail (e-mail) at the e-mail address that you provided on the Patient Registration form regarding general information about your child's progress, scheduling, and cancellations.

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Cancellations/No Show

All appointments missed without 24 hours or more cancellation notice will be considered a "no show" and billed at the full cost of the scheduled appointment. Cancellations with 24 hours or more notice will not be charged.

Waiting Room and Treatment Etiquette

You are more than welcome to accompany your child into the treatment room. We ask that no more than one adult (and infant) be present in the therapy room with your child. We ask that you do not bring siblings, friends, cousins, or other individuals into the therapy room with your child as it is very distracting for both the child and the therapist. If you bring other children with you to wait in the waiting room, adult supervision of those other children are required at all times and we ask that you arrange for an adult to stay in the waiting room to supervise them. The parent/guardian may not leave the office during your child's appointment.

In-Treatment Media Consent

Upon signing the Patient Acknowledgement at the end of this document, you give permission for you and/or your child to be video recorded during evaluation and treatment. Video recording is optional and at the discretion of the therapist. You understand that this video may be used as an educational tool during evaluation and therapy, and may be shown to other health professionals referenced in this document, for analysis and interpretation. You also understand that you will receive no financial compensation for this video recording.

Confidentiality

Your privacy is very important to us. We strongly recommend that you review the Privacy Notice for important details regarding policies for maintaining confidentiality (see below). In particular, you should be aware that we will only contact you via the means that you have specifically authorized in your new client paperwork. If you would like us to exchange information with persons other than yourself and health professionals referenced in this document, an Authorization for Release of Information Form must be completed and submitted to the office.

Termination

At our discretion, LKS & Associates may terminate a client based on their behavior, and/or their family's behavior that may interfere with the client-therapist relationship and the client's success, as well as any breach of the terms of this agreement.

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3. CREDIT CARD AUTHORIZATION

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Name on Card:
Please circle one: MasterCard Visa American Express Discover
Credit Card Number:
Expiration Date:
Security Code:
Credit Card Billing: Address: City: State: Zip Code:
I authorize this credit card to be charged if I have not paid my invoice by the 10th of the month. I understand that my credit card will be charged on the 11th day and will include an additional 3.5% processing fee. Date: Cardholder's Signature:

4. PATIENT PRIVACY NOTICE

LKS & Associates is required by law to keep your health information private and confidential. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

As also required by law, we provide access to a copy of the LKS & Associates Privacy Notice. This notice tells you how your health information may be used and shared and how you may get access to this information. You can request a paper copy of the Privacy Notice from the office of LKS & Associates, or view and download the notice on the LKS & Associates website at www.lisakleinspeech.com.

By signing the below Patient Acknowledgement you are giving LKS & Associates permission to discuss you or your child's case and share information with the health professionals referenced in this document, either in person, or via email or phone.

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5. PATIENT ACKNOWLEDGEMENT

This form must be completed and signed before services can be initiated. If the client is under the age of 18 years, it must be signed by a legal parent/guardian.

By signing below, you are acknowledging (1) that you have provided true and accurate patient information in the Patient Registration, Acknowledgement, and Agreement form, including Credit Card Authorization, (2) that you have read, understood, and agreed to the terms and conditions in the Patient Policies, and (3) that you have been given access to a copy of the Patient Privacy Notice and read, understand, and agree to its content.

Patient's Printed Name: _____ Date:_____

Parent and/or Guardian's Printed Name if Patient is a minor: _____

Patient's Signature or Parent/Guardian's Signature if Patient is a minor:_____