Kathy Ziatas | speech pathologist

22 Letchworth Centre Avenue
Salter Point WA 6152
Tel: +61 8 9450 6939
Fax: +61 8 9450 6972
e-mail: chris@kzspeech.com.au

PO Box 7001
Karawara WA 6152

Initial Client Information Sheet

Date: ____________________________

Child/Client

Last Name______________________________ First Name__________________________ O Male O Female

Address ____
Street

Address ____
Suburb/Town State Postcode

Birth date:_______________________________________

Home Phone: ______________________________ Mobile: _________________________________

e-Mail Address: ____

Parent/Guardian Concern:____

Do you/your child have any allergies?: O Yes O No

If **YES** please indicate type of allergies: ____

Service(s) Requested:

O Speech and Language Assessment
O Tuesday/Thursday/Friday Fun
O WordFun
O Speech and Language Therapy
O Social Skills Groups
O Literacy Groups
O Diagnostic Assessment
O Occupational Therapy

Parent/Guardian (Please state "AS ABOVE" if the same)

Parent/Guardian Name:____________________________________ Relationship to Client:_________________

Home phone: ______________________________ Business phone:__________________________________

Address if different than client:____

Parent/Guardian e-Mail: ____

Doctors Details

Doctors name: ____________________________________ Office phone: ______________________________

Primary Clinic name and address:____

Emergency Contact Details

Emergency Contact Name: ____ Phone: _____________________

KathyZiatas | speech pathologist

22 Letchworth Centre Avenue
Salter Point WA 6152
Tel: +61 8 9450 6939
Fax: +61 8 9450 6972
e-mail: chris@kzspeech.com.au

PO Box 7001
Karawara WA 6152

Payment Information

* Private Pay

O Cash/Cheque/Credit Card at time of service

O Monthly Automatic Credit Card Payments (Please complete **Authorization to Charge Credit Card**)

* Private Health Insurance Fund

O Please specify Health Fund ___________________________________

O Government Assisted - FAHCSIA Funding
Better Start
Medicare EHPC
Medicare - Helping Children with Autism

Account Payment

I request and authorize **Kathy Ziatas Speech Pathology** to provide speech evaluation/therapy services to the above-named client. I agree to pay for services provided by **Kathy Ziatas Speech Pathology** in a timely manner according to the **Kathy Ziatas Speech Pathology** payment policy that I have both read and signed.

____ _____________________________________

Signature of Client, Parent, or Legal Guardian Name

Date _____________________________________

KathyZiatas | speech pathologist

22 Letchworth Centre Avenue
Salter Point WA 6152
Tel: +61 8 9450 6939
Fax: +61 8 9450 6972
e-mail: chris@kzspeech.com.au

PO Box 7001
Karawara WA 6152

Authority to Obtain / Release Information

I, ______________________________, give **Kathy Ziatas Speech Pathology**, my consent to obtain and/or release information on __________________________________, verbally and/or in the form of written evaluations and progress notes to the following persons or agencies listed below:

Physician:____

Address:____

Telephone:____

Reason:____

School:____

Address:____

Telephone:____

Reason:____

Other:____

Address:____

Telephone:____

Reason:____

Other:____

Address:____

Telephone:____

Reason:____

_____________________________________ _____________________________

Client/Parent/Guardian Signature Date

22 Letchworth Centre Avenue
Salter Point WA 6152
Tel: +61 8 9450 6939
Fax: +61 8 9450 6972
e-mail: chris@kzspeech.com.au

PO Box 7001
Karawara WA 6152

PARENT LETTER
(Parent and Cancellation policy)

In order to provide the highest quality of services to our clients, the following policies have been established by **Kathy Ziatas Speech Pathology**. Please review the policies and contact us with any questions or concerns that you may have.

Speech & Language Therapy Policies

1. Your child's schedule for speech/language sessions is the same each week (unless specified by our clinician). If your child will not be able to attend his/her session due to a conflict (other appointments, vacation, etc) you must call **Kathy Ziatas Speech Pathology** on 9450 6939 as early as possible but no later than 3 hours before the scheduled appointment time, to reschedule or cancel. If notice is not received by **Kathy Ziatas Speech Pathology** via phone or voice mail, it will be considered a missed appointment. You will receive this same courtesy from your clinician in the event that they need to cancel a session.

2. Missed appointments will result in a cancellation fee. If notice is given, but less than 3 hours before the scheduled appointment, the fee will be $30.00. If *no* notice is given, you will be charged the full session fee. These cancellation fees will be applied *per occurrence*. This fee applies to all clients, and will be billed directly to the family.

3. Following 2 missed appointments, without notice given, **Kathy Ziatas Speech Pathology** has the right to discontinue services. We certainly do not want this to happen, so please try to plan ahead when making other appointments or planning other events that would require your child to miss school and/or therapy for the day.

4. We ask that a 14-day (2 weeks) notice be given, if a family chooses to discontinue therapy services. If you, the parent/guardian, are not comfortable with your child's current therapist, please contact Kathy Ziatas via phone (9450 6939) or by e-mail (kathy@kzspeech.com.au) to arrange an appointment to discuss your concerns. It may be determined that another therapist within the practice may be better suited to your current needs.

Please be sure to remember these policies, and your child's weekly schedule, when making other appointments for your child. If your child is sick on one of these days, please call to advise as early as you can. We can then reschedule the appointment.

Thank you for understanding our need for you to follow these policies. Please feel free to call us at any time to discuss any questions you may have regarding these policies. We look forward to working with you and your child in the upcoming weeks and months.

Sincerely,

Kathy Ziatas Speech Pathology

ACKNOWLEDGEMENT OF PARENT POLICY & CANCELLATION POLICY

I acknowledge that I have received a written copy of the **Kathy Ziatas Speech Pathology** Parent Letter and Cancellation Policy. This policy states that I will give appropriate notice for cancellation of my child's appointments or it will be considered a missed appointment.

I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice.

I understand that by signing this form I am solely responsible for charges due to a missed appointment and will pay the charges or therapy sessions may be terminated.

Client Name:____

Date of Birth:_______________________

____
Name (Printed) of Patient or Guardian

____ __________________________
Signature of Patient or Guardian Date

Kathy Ziatas | speech pathologist

22 Letchworth Centre Avenue
Salter Point WA 6152
Tel: +61 8 9450 6939
Fax: +61 8 9450 6972
e-mail: chris@kzspeech.com.au

PO Box 7001
Karawara WA 6152

Payment Policy

Kathy Ziatas Speech Pathology has adopted the following payment policy effective March 1, 2012:

Payment and Invoices

Unless prior arrangements have been made payment is required at the time of service.

Payments can be made by EFTPOS, Credit Card, Direct Debit, Cheque or Cash.

A receipt will generally be provided at the time of payment which will contain all the necessary information you will require to submit the claim to your insurance company for possible reimbursement.

ACKNOWLEDGEMENT
OF
PAYMENT POLICY

I acknowledge that I have received a written copy of the Payment Policy for **Kathy Ziatas Speech Pathology**. This policy states that I am required to pay for services prior to or at the time that services are received.

I acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice.

I understand that by signing this form I am solely responsible for all charges related to services and for any late or insufficient fund fees.

Client Name:____

Date of Birth:______________________

____
Name (Printed) of Patient or Guardian

____ __________________________
Signature of Patient or Guardian Date

KathyZiatas | speech pathologist

22 Letchworth Centre Avenue
Salter Point WA 6152
Tel: +61 8 9450 6939
Fax: +61 8 9450 6972
e-mail: chris@kzspeech.com.au

PO Box 7001
Karawara WA 6152

Authorization to Charge Credit Card

Please complete **ONLY** if you allow Kathy Ziatas Speech Pathology
to make automatic deductions on your behalf.

Client's Name: ____

Client's Date of Birth: ____

Parent/Guardian Name: ____

I elect to pay by **credit card** for all therapy payments.

I authorize the **Kathy Ziatas Speech Pathology** to process a variable automatic charge to the credit card specified below for payment of fees invoiced to me as a client of the **Kathy Ziatas Speech Pathology**. I agree to pay the amount charged in accordance with my credit card issuer agreement. My authorization is effective on this date, as indicated by my signature below*.

O Visa O Mastercard

Credit Card Number __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ **Exp. date** __________

Credit Cardholder Name: ____

Credit Cardholder Signature*: ______________________________ **Date*:** __________

Telephone Number: ____

Billing Street Address: ____

City /State / Postcode: ____