Communication Clubhouse
Deborah Hoffman, MA CCC-SLP & Associates
Speech Language Therapy for Children

Application for Therapy Services

Please complete the Application Forms and return as soon as possible. *To reserve consideration on the schedule for the 2021-22 Fall–Spring session, an application fee is required, and an invoice will be sent upon receipt of the application form.* This nonrefundable $75 application fee covers administrative time spent on: reviewing the application, formulating the 2021-22 schedule, and related communication.

Therapy sessions are offered on an ongoing, weekly basis beginning the week of Monday, September 20, 2021, and continue through the week ending May 26, 2022.

Office address for in-person sessions:
The office is located at 1190 S. Bascom, San Jose, CA 95128, Suite 104.

In case of an extreme spike in Covid cases or a change in Covid policies set by Santa Clara County, all classes will be held over Zoom, at the originally scheduled meeting time. Parents will be informed as soon as possible if there is a change in venue.

Teletherapy option: Monday afternoons are reserved for individual, 25 minute teletherapy sessions for school age children.

Fees

45 minute *group* session - $130 per session per client
45 minute *individual* session - $170 per session

25 minute *individual* session - $85 per session

Notes: The final 5 minutes of each 45-minute therapy session and the final 5 minutes of each 25-minute therapy session are reserved for therapist's time to write clinical notes. Please plan to arrive 5 minutes early to pick up your child at the end of the session so that we can maintain a timely transition between sessions. The therapist is available to answer specific questions through email or a planned phone meeting. *Clinical notes are delivered electronically to parents within a few days of the session.* These clinical notes contain vital information regarding the session focus and activities.

Professional Time – billed at $170 per hour
Consultation with parents, schools, workplaces, other professionals as well as report writing, phone conversations longer than 15 minutes, and insurance letters/forms will be billed for time spent, at the hourly rate.

Travel Fee – billed at an additional $25 per hour for onsite session visit to a school or a home visit.

Deposit and Administrative Fee:

The $75 administrative fee will be billed upon receipt of the application form, and payment is due upon receipt of the invoice.

If there is not appropriate placement at the time of scheduling, the client can choose to be placed on a waiting list and the $75 administrative fee retained to account for time spent working on a placement.

Therapy Calendar Fall-Spring 2021-22 Session

Therapy sessions are offered on an ongoing, weekly basis beginning the week of Monday, September 20, 2021 and continue through the week ending May 26, 2022.

We will be closed on these dates during the 2021–22 Fall–Spring session:

- Mon – Fri November 22-26 (Thanksgiving week)
- December 20, 2021, through January 9, 2022. Sessions begin again the week of January 10, 2022.
- Presidents Week: February 21 – 24, 2022
- Spring Break: April 4 – 8, 2022

We look forward to seeing you this year!

Application begins on the next page.

Continuing clients: Please complete the following on page 3: your child's name and birthdate, your contact information, and the Additional Information section. Since we know your child, you can then skip to page 6.

Client Information

Office use only
Date Appl. Rec'd:

Date: _____

Client's Name: _____ **Age** _____ **Birth date** _____ **Gender** _____

Parent #1 Name --- Please circle: mother father guardian_____

Parent #2 Name --- Please circle: mother father guardian_____

Parent #1
Address: _____

City/State/Zip Code: _____

Parent #1 Home Phone: _____

Parent #1 cell #: _____

Parent #1 work #: _____

Parent #1 email: _____

Parent #2
Address: (if different from parent #1) _____

City/State/Zip : _____

Parent #2 Home Phone: _____

Parent #2 cell #: _____

Parent #2 work #: _____

Parent #2 email: _____

Emergency Contact: Name:_____ Phone:_____ Relationship to client: _____

Siblings name(s) and ages: _____

Who can we thank for referring you? _____

Additional Information

Current Educational Setting:

Name of school /grade _____ Aide____ SDC____ Private____

Home Schooled _____ Combination (explain) _____

Current Services: OT_____ Speech_____ ABA_____ Other: _____

Does your child have a given diagnosis? Yes _____ No _____

If yes: Diagnosis of _____ given on (date) _____ by (provider) _____

Specific numeric code _____(example F80.2)

Allergies or foods to avoid: _____ **Epi-pen: Yes No** (please circle)

Parent Questionnaire

In order to better place your child, please answer the questions below, to the best of your ability.

Communication Skills

Expressive language – My child's use of vocabulary and sentence structure appears to be:
( )Advanced ( )Age expected ( )Slightly delayed ( )Significantly delayed

Receptive language – My child's understanding spoken language and communication appears to be:
( )Advanced ( )Age expected ( )Slightly delayed ( )Significantly delayed

Articulation – My child's use of speech sounds, clarity of speech appears to be:
( )Advanced ( )Age expected ( )Slightly delayed ( )Significantly delayed

Please answer these questions for children entering 1st grade or younger.

Communication skills continued:

Please check any areas of concern

- ☐ Articulation (pronouncing words and sounds more clearly)
  - Specific sounds, please list: _____
- ☐ Does not yet speak
- ☐ Just beginning to combine words
- ☐ Delayed vocabulary development
- ☐ Delay in putting phrases and sentences together
- ☐ Speaking in grammatically correct sentences
- ☐ Needs to talk more; responds using short answers and little elaboration
- ☐ Learning how to *ask* questions
- ☐ Learning how to *answer* questions when asked
- ☐ Learning to tell about an experience, narrative language, using expected sequence and detail, in his/her own words
- ☐ Learning to retell a story using expected sequence and detail, in his/her own words
- ☐ Listening to a story and being able to answer questions about it
- ☐ Social Language/Pragmatics - relating to other children in expected ways

Please answer these questions for children entering grades 2 and up.

Communication skills continued:

Please check any areas of concern

- ☐ Articulation (pronouncing words and sounds more clearly)
  - Specific sounds: _____
- ☐ Delayed vocabulary development
- ☐ Narrative language – retelling in succinct manner
- ☐ Listening / Auditory Processing
- ☐ Social Language/Pragmatics/relating to other people in expected ways

Please answer these questions for all children

If I were to observe your child playing or hanging out *at home*, what would I notice about him/her?

If I were to observe him/her with others in unstructured *social* settings (ie; *playground, hangouts*), what would I notice about him/her as compared to others?

If I were to observe him/her *in a more structured setting,* such as the classroom, what would I notice about him/her as compared to others?

What are his/her preferred activities when alone? When with others?

Specific Concerns:

Child's Strengths:

Your Goals for your Child:

Any additional information, please attach a note to this application. Thank you.

Application continued on next page

Session Preference

Today's Date: _____

Child's Name and birthdate: _____

Please indicate your first, second and third preferences with a 1, 2, or 3 on the chart below. There can be more than one time indicated in each level of preference. Please choose as many options as you can.

Please note 2:30 – 5pm time slots are reserved for groups priority. Depending on demand, individual sessions *may* be available in the afternoons. Monday afternoons are reserved for school age individual 25-minute teletherapy sessions.

Therapy session preference

Time	Monday	Tuesday	Wednesday	Thursday
Morning	Reserved for school and home visits	Tues AND Thurs 3 and 4 year old Speech/OT Group 9:00 – 10:45	Reserved for school and home visits	Tues AND Thurs 3 and 4 year old Speech/OT Group 9:00 – 10:45
Noon	12:00 1:00	12:00 1:00	12:00 1:00	12:00 1:00
Afternoon GROUP PRIORITY	Please list range Earliest: _____ To Latest: _____ **Teletherapy**	2:35 3:25 4:15	2:35 3:25 4:15	2:35 3:25 4:15

I would like _____ (number) Individual sessions per week; I would like _____ (number) Group sessions per week.

Parent/Guardian Signature _____

Policies Agreement

Please read carefully and initial each box, then sign and date below.

☐ **1. Illnesses: Please do not bring your child to therapy if he or she is ill.**
In consideration of the other clients in the clinic and the therapists, please do not bring children who have cold symptoms, stomach virus, a contagious illness, or a fever, or in case of a possible COVID-19 exposure. We also ask that you keep your child home for 24 hours after a fever or stomach virus. Contact the therapist as soon as you are aware of this situation to let her know of this unexpected absence so that she can alter her planning of the session with the other child(ren).
If the therapist is not informed of illness prior to the session start time, the session will be charged.

☐ **2. Absences: Please call at least 24 hours in advance if a cancellation is necessary.** Please notify therapist of any planned absences (such as family vacations and trips) at least two weeks in advance. Please keep these to a minimum during the school year, as the office will be closed for several weeks during the winter break as well as other holidays such as Thanksgiving and New Year's.

If an absence occurs and the therapist is not notified, the session will be charged at the full rate. This fee is not covered by insurance. Only two absences for reasons other than illness or emergency during the 2021-22 session (September through May) will be considered excused and not billed. *Any subsequent absences will be considered unexcused and will be billed at the normal rate.*

Additional note about absences: Consistent weekly attendance is crucial to the flow and progress of the entire group and the individual. Every absence affects the progress of the entire group and the individual. *Therefore, if absences for work obligations, transportation complications (of which there are potentially many) and frequent vacations during the school year occur, it will be necessary to charge for the sessions.*

☐ **3. Inconsistent attendance:** We strongly believe that consistent input and attendance are essential to a child's, and the group's, benefit and progress in therapy. If a child misses more than 2 consecutive appointments, the third appointment will be charged at the full rate regardless of notification. Special consideration will be given to cases of severe illness or family emergency. If a child needs to discontinue therapy for any length of time, his or her regularly scheduled time cannot be reserved. In this case families may choose to go on the waiting list for another therapy time or may pay full fee to hold that space. If there is a pattern of inconsistent attendance and frequent absences, therapy will be discontinued at the discretion of the clinic director.

☐ **4. Discontinuing therapy: A two-week notification is required if requesting to stop therapy.** Consideration will be given for family emergencies and additional circumstances, at the discretion of the clinic director. All remaining fees are due on or before the final session.

☐ **5. Timely Payments: Prompt payment in full is expected.** Payment is due upon receipt of invoice. If insurance is covering your child's therapy, we ask that you handle such arrangements and request reimbursement be sent directly to you. If payment is **15** days past due, a late fee of 10% of the total bill will be imposed. Therapy will be discontinued until payment is received. If specific insurance invoices or other documentation are required after monthly payment is obtained, a fee will be applied for time spent based on the hourly consultation fee.

☐ I understand and agree to the Communication Clubhouse policies stated above.

_____ _____
Child's Name Child's Date of Birth

_____ _____ _____
Parent/Guardian's Name Parent/Guardian's Signature Date

Email and Remote Learning Platform Release

Please check the boxes below and then sign.

( ) **As the Parent or Guardian, I authorize and give permission, on behalf of the minor patient, to participate in video sessions.**

I authorize and give permission for Communication Clubhouse to send via email:

( ) Notes and observations taken during therapy sessions.

( ) Photos taken during therapy sessions.

I understand that I am under an obligation to maintain the privacy of all individuals appearing in the picture and will share these photos with **only** my immediate family. I will **not** share photos on social media if there are other people in the photo. The purpose of the photos is to enhance the therapeutic experience through encouraging the child's verbal recall of events and interactions with peers. Please share the photos with your child and encourage him/her to talk about the session and activities.

For _____ _____

Print Child's name Child's birthdate

Send to:

_____

Name Email

_____

Name Email

This authorization is valid for one year from the date below, or until terminated by the parent/guardian (whichever occurs first).

→ _____ _____

Parent/Guardian's Signature Date

Consent to Release Information

I authorize my Speech Language Pathologist at Communication Clubhouse, to release or receive information for program planning and information related to my child's treatment. This consent is valid for one year from the date below, or until terminated by the parent/guardian (whichever occurs first).

The following Persons or Organizations are authorized to release or receive information:

Name	Contact Information

By signing this agreement, I verify that I have read the above consent and have the authority to sign and give permission for this child. I also understand that I have the right to revoke this consent at any time.

Child's name_____ DOB: _____

Parent/guardian's name: _____ Relationship: _____

Signature: _____ Date: _____

Application continues on next page

Consent for In-Person Treatment

Child's Name: _____ ***Date:*** _____

(please circle) Mother Father Name _____ **Cell Phone** _____

(please circle) Mother Father Name _____ **Cell Phone** _____

Other Emergency Contact Person:

Name _____ Relationship _____

Phone Numbers: _____

I give permission for my child _____ to receive speech and language therapy treatment from Communication Clubhouse. Communication Clubhouse complies with Santa Clara County Department of Public Health Orders and ASHA recommendations for providing in-person speech and language therapy.

I am aware of the inherent risks of exposure to COVID-19 despite precautions put in place including social distancing and the use of Personal Protective Equipment. I will not hold Communication Clubhouse liable for any exposure to COVID-19 to me or my child. Furthermore, I agree to inform Communication Clubhouse of any changes in our child's and family's social exposure including travel, camp attendance, social groups, or any other social gathering environment. If such events that may lead to exposure occur, Communication Clubhouse reserves the right to postpone services for at least 14 days following the notification of possible social exposure to COVID-19.

I acknowledge the increased risk involved in off-site therapy and small group therapy and will not hold Communication Clubhouse liable for injury or incident that might occur while off-site. One parent/guardian per session shall be present during each off-site session. I agree to participate by being present and able to assist as needed in group therapy sessions.

By signing below, I hereby release and agree to hold Communication Clubhouse harmless from, and waive on behalf of myself, assignees, heirs, distributees, guardians, and legal representatives any and all causes of action, claims, demands, damages, costs, expenses, and compensation for damages or loss to myself and/or property that may be caused by any act, or failure to act of the clinic, or that may otherwise arise in any way in connection with any services received from Communication Clubhouse. I agree to release Communication Clubhouse from any and all liability for the unintentional exposure or harm due to the Coronavirus (COVID-19).

I HAVE CAREFULLY READ THIS RELEASE AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A ***RELEASE*** OF ***LIABILITY*** AND A CONTRACT BETWEEN ME AND COMMUNICATION CLUBHOUSE AND SIGN IT OF MY OWN FREE WILL.

The signature of both parents is required. This form is current for one year following the date of signature, or until the parent or guardian requests a change of status.

_____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date