FINANCIAL INFORMATION SPEECH-LANGUAGE EVALUATION/THERAPY

Children's Program Speech Language Pathology (SLP) services are in network with most policies from the following insurance plans:

- Blue Cross Blue Shield
- Providence
- Pacific Source
- Cigna
- Aetna
- First Choice

Insurance benefits for speech and language services vary greatly. It is your responsibility to understand these insurance benefits before your visits occur. We cannot guarantee services will be covered/paid for by your plan.

We strongly recommend a call to your insurance company PRIOR TO YOUR FIRST VISIT. Use the questions below to gather information about in-network or out-of-network benefits.

IN NETWORK:

1) **Is speech language therapy a covered benefit in my plan?**

   You may need to provide the insurance company with the procedure (CPT code) for the visit. Common CPT procedure codes include the following:

   - SLP evaluations: 92521, 92522, 92523, 92610
   - SLP therapy/treatment: 92507, 92526, 92508

   You may also be asked for a diagnosis (ICD-10) code. If your child doesn't yet have a diagnosis your clinician will identify the diagnosis codes during the initial evaluation.

2) **How many visits are allowed per year? Is this benefit combined with other therapy services** (e.g. occupational therapy, chiropractic, physical therapy**?) Are visits counted by a calendar or plan year?**

3) **Are benefits subject to a deductible? What is the deductible? Once met, what is the co-payment or co-insurance?**

4) **What are the exclusions of the benefit plan? Be aware that plans may exclude specific diagnosis codes such as developmental codes, or may provide coverage only for injury, illness, or congenital anomalies).**

5) **Is pre-authorization and/or a physician referral required?**

   If Children's Program is in-network with your insurance, you will be responsible for paying the deductible and copayment or co-insurance at each visit. You will be responsible for the full cost of appointments that are not covered due to benefit limits, policy exclusions or if the policy visit limit is exceeded.

OUT OF NETWORK:

If Children's Program is not in network with your insurance, you will be responsible for paying for services in full at the time of each appointment. Ask these questions to determine if you can obtain reimbursement by self-billing the insurance company/.

1) **Does my plan offer out-of-network benefits for speech language therap**y?

   You may need to provide the insurance company with the procedure (CPT code) for the visit. Common CPT procedure codes include the following:
   - SLP evaluations: 92521, 92522, 92523, 92610
   - SLP therapy/treatment: 92507, 92526, 92508

   You may also be asked for a diagnosis (ICD-10) code. If your child doesn't yet have a diagnosis your clinician will identify the diagnosis codes during the initial evaluation.

2) **How many visits are allowed per year? Is this benefit combined with other therapy services (e.g. occupational therapy, chiropractic, physical therapy?) Are visits counted by the calendar, or the plan year?**

3) **Are benefits subject to a deductible? What is the out-of-network deductible? Once met, what is the usual and customary reimbursement amount for the procedure being billed? What will be the out-of-pocket cost?**

4) **What are the exclusions of the benefit plan? Be aware that plans may exclude specific diagnosis codes such as developmental codes, or may provide coverage only for injury, illness, or congenital anomalies)**

5) **Is preauthorization and/or a physician referral required?**

6) **What paperwork/information will I need to provide to my insurance company for reimbursement?**

7) **How and where do I submit claims? What is the time period between submission and reimbursement? Is pre-authorization and/or a physician referral required?**

CHILDRENS PROGRAM SPEECH DEVELOPMENT QUESTIONNAIRE

Please complete this form only if you have a scheduled evaluation appointment with
our Speech-Language Pathologist.

Child/Patient's Name: ______________________________ ____________________ B.D. __________
Last, First (Full Legal Name) (Name to Address Child)

Age ______ Grade_______ Gender Identity: ☐M ☐ F ☐Nonbinary ☐ Other __________ Birth Sex: ☐ M ☐F

School ____________________________________

Person completing form: ☐ Biological Parent ☐ Adoptive Parent ☐ Step Parent ☐Grandparent ☐ Other
Other, describe______________

Child lives with ____

Referred by (check all that apply): ☐ self ☐ physician ☐ client/friend ☐ school ☐ clinician ☐ insurance

Have you had services at the Children's Program before? ☐ No ☐ Yes

(if yes, describe) ____

Specific areas of concern (check all that apply)

☐ Late talker
☐ Speech sound development (e.g. has trouble pronouncing or sequencing certain sounds or words, mumbles or is hard to understand)

How intelligible is your child to the following listeners?

Parents/very familiar listeners: Choose percent.

Somewhat familiar listeners (e.g. peers/teacher/extended family): Choose percent.

Strangers: Choose percent.

☐ Expressive Language (e.g. difficulty organizing/expressing thoughts and ideas, vocabulary and word finding, use of accurate grammar)
☐ Receptive Language (e.g. difficulty following directions, understanding instructions)
☐ Literacy – reading/writing/spelling
- ☐ Decoding (sounding out words when reading)
- ☐ Fluency (speed and accuracy when reading)
- ☐ Spelling
- ☐ Written Expression
- ☐ Reading Comprehension

☐ Voice quality (e.g. hoarse, raspy, high-pitched)
☐ Stuttering
☐ Social Communication/Pragmatics (reading social cues, conversational skills, nonverbal communication)
☐ Play skills

Today's Date _______________

☐ Feeding and Swallowing (e.g. limited food repertoire, tongue-thrust swallow, unable to manage age appropriate diet)
☐ Other:

When did you first start having the above concerns?
Has your child had previous speech language pathology evaluations or therapy? If yes, please describe:

Developmental Information:

As an infant, did your child babble and play with sounds? ☐Yes ☐No ☐Less than expected ☐Later than expected At about what age did your child meet the following milestones? Spoke first words: Used 2-word phrases: Sat alone: Stood alone: Crawled: Walked alone: Dressed self: Bladder trained: Bowel trained: Was child's rate of growth seemingly normal? Was development interrupted by anything? Does your child have current difficulty with gross or fine motor tasks?

Medical History

Current diagnoses:

Any other suspected diagnoses:

Current Medications:

Prescribing Physician:

Please note any prenatal or birth complications:

Check all that apply: ☐ Adenoidectomy ☐ Tonsillectomy ☐ Allergies. If yes, Describe: Click or tap here to enter text. ☐ Breathing difficulties/Asthma ☐ Frequent upper respiratory infections ☐ GERD/Acid Reflux ☐ Frequent headaches ☐ Frequent colds ☐ Sinus problems	☐ Frequent ear infections ☐ Tubes in ears ☐ Head injury ☐ Seizures ☐ Loss of consciousness ☐ Sleeping difficulties/disorder. If yes, please describe: Click or tap here to enter text. ☐ Snores ☐ Tosses and turns ☐ Doesn't wake rested ☐ Other significant medical information: Click or tap here to enter text.

Child's Name ___________________________ Date:

☐ Vision problems/Describe:

Dental and Oral History

History or current symptoms. Check all that apply: ☐ Cavities ☐ Thumb or finger sucking ☐ Pacifier use ☐ Nail biting ☐ Excessive lip licking or lip biting ☐ Other Chewing or sucking habits ☐ Chin leaning ☐ Excessive saliva/drooling - in the corners of the mouth, during speech, while eating, or during sleep ☐ Mouth breathing ☐ Teeth Grinding or clenching ☐ Jaw pain ☐ Temporomandibular Joint Disorder (TMJD) ☐ Suspected or diagnosed tongue tie	☐ Frenectomy. If yes, at what age? Who performed? ☐ Orthodontics or orthodontics planned If yes, describe: How often does your child: Brush teeth? Floss? ☐ Other significant dental or oral health history:

Feeding History:

Was your child breast fed, bottle fed, or both? For how long?

How did early feeding go?

Check all that apply: ☐ Difficulty with breast feeding (e.g. painful or shallow latch, poor supply, difficulty getting adequate transfer) ☐ Difficulty with bottle feeding (e.g. needed special nipple or special formula) ☐ Slow eater ☐ Fast Eater ☐ Messy eater	☐ Loses food or liquid from the mouth ☐ Eats with mouth open ☐ Uses a sippy cup ☐ Drinks more than one glass of liquid during meals/needs liquid to wash food down ☐ Frequently belches ☐ On a special diet. If yes, please describe: Click or tap here to enter text. ☐ Refuses certain foods/picky eating habits

Child's Name: ___________________________ Date:

☐ Difficulty drinking from a cup ☐ Difficulty chewing ☐ Difficulty swallowing ☐ Digestive problems ☐ Constipation ☐ Coughs/chokes when eating ☐ Gags when eating	☐ Refuses many foods/very picky/restricted eating habits If picky or restricted, what does your child avoid? (e.g. textures, flavors, nutritional categories) Click or tap here to enter text. ☐ Other feeding concerns:

Is there anything else you'd like the speech language pathologist to know about your child?

Child's Name ________________________ Date: