**Jennifer Asdorian, M.S., CCC-SLP**
**Pediatric Speech and Language**
**Pathologist Creative Therapy Solutions, LLC**
**MD License Number: 04043**
**(301) 933-7880 FAX: (301) 933-7911**

This packet contains forms to be completed and returned by mail or fax prior to your appointment. Please return all forms by mail or fax one week prior to the evaluation or treatment date. If you fax the forms, please bring the originals on the date of the appointment. If you have additional information, such as school or therapy reports, please forward those as well. Should you have questions about the completion of these forms, please call (301) 933-7880, ext.1. Please return forms to:

Jennifer Asdorian, M.S., CCC-SLP
ITS: Developmental Therapy Services, Inc.
10605 Concord Street, Suite 102
Kensington, MD 20895

Sincerely,

Jennifer Asdorian, M.S., CCC-SLP

Please make sure to complete the following items to help prepare for the evaluation or initiation of treatment.

1. Complete the packet.

2. Send or fax the completed packet. If the packet is faxed, please bring original forms to evaluation/treatment date.

3. Send other relevant reports.

**Jennifer Asdorian, M.S., CCC-SLP**
**Pediatric Speech and Language Pathologist**
**Creative Therapy Solutions, LLC**
**MD License Number: 04043**

**Current Fee Schedule and Payment Policy**

(June 1, 2014)

The following is the current Fee Schedule and Payment Policy for services to be provided to your child by Creative Therapy Solutions, LLC, Jennifer Asdorian, M.S., CCC- SLP and/or its consultants (the "Company"). Please understand that the Company reserves the right to change and/or modify the fees set forth below, but you will receive thirty (30) days advanced notice of any increase in such fees. All fees and costs shall be due and payable in accordance with the Agreement to Terms of Payment.

## Fee Schedule

| | |
|---|---|
| Speech-Language Therapy | $130 per 60 minute session |
| Feeding Therapy | $130 per 60 minute session |
| Cranial-Sacral Therapy | $150 per 60 minute session |
| Consultations | $150 per 60 minutes |

## Payment for Services

For your convenience, we accept Visa and MasterCard as well as debit from your checking or savings account. We do not accept checks. Credit Card and Debit charges will be processed on the first day of each month and itemized statements will be sent to you. Please sign and return the Credit Card/ Debit Transaction Form along with the remainder of the forms.

## Cancellation and No-Show Policy

Cancellations **less than 24 hours in advance** of the scheduled appointment will be billed at the full rate if the session cannot be filled. For all cancellations, please call 202-486-0845. Appointments that are not cancelled are considered "no-shows". These appointments will be billed at the full rate.

**Jennifer Asdorian, M.S., CCC-SLP**
**Creative Therapy Solution, LLC**
**Pediatric Speech and Language Pathologist**
**Private Practice & Consultation**

## Credit Card/ Debit Transaction Processing Authorization Form

☐ **Yes,** I would like you to automatically charge my credit card for services rendered each month.

☐ **Yes**, I would like to have my checking account debited for services rendered each month.

| Card Type | Number | Exp. Date | 3 digit code |
|---|---|---|---|
| ☐ **Visa** | _____ | _____ | _____ |

Billing Address and Name on the card:

_____
_____
_____

| | Number | Exp. Date | 3-digit code |
|---|---|---|---|
| ☐ **MasterCard** | _____ | _____ | _____ |

Billing address and Name on the card:

_____
_____
_____

By signing this Agreement, and marking the box noted above, the undersigned does hereby agree as follows: (i) the undersigned does hereby authorize and agree that Creative Therapy Solutions, LLC and/or its duly authorized agent (the "Company") has the right from time to time to charge to the above identified credit card and/or debit the account identified above any and all amounts that are owed to the Company and/or its consultants, (ii) the undersigned agrees that its signature on this Agreement shall be deemed its signature on any sales charge receipt or other form and if any merchant services, credit card company, or bank requests to view the undersigned signature on a sales charge receipt or other form, the Company may provide such company with a copy of this Agreement and such shall be deemed conclusive proof that the undersigned approved and authorized the charge and/or debit at issue, and the undersigned does hereby waive any right to dispute its authorization to such charge based on an invalid or non- existent signature. The undersigned understands and agrees that the above payment option and charges or debits will continue each month for services rendered by the Company and/or its consultants until such time as the undersigned has provided written notice to the Company to stop such automatic charges and/or debits. The undersigned shall be fully responsible for ensuring that it has sufficient credit and/or funds to cover the charges or debits, and shall indemnify the Company against all costs incurred as a result of any declined charge or debit.AGREED AND ACCEPTED:Cardholders Signature: _____ Date: _____

Print Name: _____*All credit cards will be processed on the first day of each month. **All Debits will be processed on the first day of each month.

I, _____ authorize Creative Therapy Solutions, LLC to send paid invoices via electronic mail in PDF format to _____.
Signature:_____ Date:_____

Revised 4/2013

**Jennifer Asdorian, M.S., CCC-SLP**
**Pediatric Speech and Language Pathologist**
**Creative Therapy Solutions, LLC**
**MD License Number: 04043**

## Agreement to Terms of Payment

I, _____(print *name),* acknowledge and accept full and complete responsibility for payment of all services rendered to my child or any child under my care by Creative Therapy Solutions, LLC, Jennifer Asdorian, M.S., CCC-SLP, and/or its consultants. I acknowledge that I have received written explanation of the fee schedule, cancellation policy, and payment policy and I agree to both.

I understand that health insurance policies are an arrangement between my insurance company and myself, that all services rendered to my child or any child under my care are charged directly to me, and that I am personally responsible for payment. I understand that agreements regarding fee schedules, charges for cancelled appointments and late payment fees are between myself and Creative Therapy Solutions, LLC and are not related to potential insurance coverage. I understand that Creative Therapy Solutions, LLC may assist me in completing forms to aid in collecting insurance benefits for services that are billable, but ultimately it is my responsibility to complete and file such forms. I agree to the release by Creative Therapy Solutions, LLC and/or its duly authorized agents of any information that is requested by my insurance company.

Signature of Parent/Guardian: _____

Print Name: _____

Date:_____

Revised 4/2013

**Jennifer Asdorian, M.S., CCC-SLP**
**Pediatric Speech and Language Pathologist**
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## Acknowledgement and Assumption of Risk

I, _____ (print *name)* acknowledge and agree to have my child (or the child under my care), _____ (print *child's name)* receive speech therapy services from Jennifer Asdorian, M.S., CCC-SLP and/or any independent contractor under the foregoing at ITS: Developmental Therapy Services, Inc. I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Jennifer Asdorian, M.S., CCC-SLP, any of their independent contractors, and ITS: Developmental Therapy Services, Inc. harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belongings.

Signature of Parent/Guardian: _____

Print Name: _____

Date:_____

**Jennifer Asdorian, M.S., CCC-SLP**
**Pediatric Speech and Language Pathologist**
**Creative Therapy Solutions, LLC**
**MD License Number: 04043**
**Referral Form**

Client's Name**:**_____

Date of Birth**:**_____

Mother's Name: _____

Father's Name: _____
Address: _____

Ph number: H: _____ Cell: _____W: _____

Email Address: _____

Current School or Program: _____Grade: _____

Phone #: _____Teacher Name: _____

Name of Primary Insurance Company:

_____ID #: _____
Group #: _____**Phone** #: _____

Name of Secondary Insurance Company:
_____

ID #: _____ Group #: _____Phone #:_____

Please describe your **parental concerns** and **primary referral reasons:** (Please include any **medications** or **allergies/special diets**)

_____
_____
_____
_____

Referral FormBriefly describe pertinent medical history such as any **surgeries, medical diagnoses** orany **history of seizures** (or attach reports that will summarize the information.):
_____
_____

_____

Please briefly describe **developmental** and **therapeutic** history or any **learning challenges** your child has:

**Jennifer Asdorian, M.S., CCC-SLP**
**Pediatric Speech and Language Pathologist**
**Creative Therapy Solutions, LLC**
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# Consent to Release Form

I, _____ (print *name)* give my permission and consent to Creative Therapy Solutions, LLC, Jennifer Asdorian, M.S., CCC-SLP, and their respective consultants and agents (hereinafter, collectively, the "Company") to discuss and speak with school officials, teachers, psychiatrists, medical doctors, other occupational therapists, insurance representatives, and other professionals (collectively, "Third Party Professionals") regarding my child (or the child under my care) as such may be needed in connection with the treatment and/or evaluation of such child by the Company.

In addition, the Company is authorized to receive any records, files, charts, and other documentation and information from such Third Party Professionals, and by signing this document, the undersigned is authorizing the release of any such information that may be held by a Third Party Professional to the Company. Any person who is provided a copy of this document may rely on it as the undersigned's full and unconditional consent to the release of any and all information pertaining to the child. The undersigned further authorizes the Company to release any and all information pertaining to the treatment and/or evaluation of the child to any Third Party Professional that may in any way be involved in the treatment and/or evaluation of the child.

The undersigned understands that some or all of the information obtained and/or released under this document may be protected under federal regulations including but not limited to HIPAA. By authorizing a release of information, as set forth above, the undersigned understands and agrees that they are agreeing to the release of such information notwithstanding the protections under HIPPA, provided, however, it is understood and agreed that the Company will maintain the confidentiality of any information obtained and will not disclose the same except as needed in the course of treating or evaluating the child.

The undersigned, for his/herself and his or her successors and assigns, does hereby hold the Company harmless from any and all claims relating to the release of information as provided above, and do hereby waive and release any claim against the Company relating to the release of such information as provided above.

AGREED AND ACCEPTED:

Signature: _____ Date: _____

**Jennifer Asdorian, M.S., CCC-SLP**
**Pediatric Speech and Language Pathologist**
**Creative Therapy Solutions, LLC**
**MD License Number: 04043**

## Consent Release Signature Form

| Name: | Date: | Initial: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I, _____ give my permission to Jennifer Asdorian, M.S., CCC-SLP at Creative Therapy Solutions, LLC to speak with the above listed professionals regarding my son/daughter _____.

**Jennifer Asdorian, M.S., CCC-SLP**
**Pediatric Speech and Language Pathologist**
**Creative Therapy Solutions, LLC**
**MD License Number: 04043**

# Parental Consent Form

## School Observation

I, _____ (print *name),* give my permission to Creative Therapy Solutions, LLC, Jennifer Asdorian, M.S., CCC-SLP, and their consultants (hereinafter, collectively, the "Company") to observe my child (or the child under my care) _____, at _ School. I understand that during this observation, the Company may speak with the classroom teacher and other professionals at the school about my child.

Signature of Parent/Guardian: _____

Print Name: _____

Date:_____

**Jennifer Asdorian, M.S., CCC-SLP**
**Pediatric Speech and Language Pathologist**
**Creative Therapy Solutions, LLC**
**MD License Number: 04043**

## GENERAL ACKNOWLEDGMENT OF FORMS

I do hereby acknowledge and agree that: (i) I have read all of the forms and documents provided to me in connection with the treatment and evaluation of my child (or the child under my care) by Creative Therapy Solutions, LLC, Jennifer Asdorian, M.S., CCC-SLP, and/or their respective consultants; (ii) I understand the meaning and intent of such forms, and agree to the provisions contained therein; (iii) I have been given the opportunity to ask questions concerning the forms and any questions that I have asked have been answered to my satisfaction, and (iv) I have signed all of the forms upon my on free volition and without any coercion from any third party.

Signature of Parent/Guardian: _____

Print Name: _____

Date:_____

**Jennifer Asdorian, M.S., CCC-SLP**
**Pediatric Speech and Language Pathologist**
**Creative Therapy Solutions, LLC**
**MD License Number: 04043**

Referred by: _____

School: _____
Address: _____
Telephone: _____

Teacher: _____
Telephone: _____

Occupational Therapist: _____
Telephone: _____
Address: _____

Physician: _____
Telephone: _____
Address: _____

Speech Pathologist: _____
Telephone: _____
Address: _____

Psychologist/Psychiatrist (circle one):_____
Telephone: _____
Address: _____

Educational Consultant: _____
Telephone: _____
Address: _____

Optometrist/Ophthalmologist (circle one): _____
Telephone: _____
Address: _____

Neurologist: _____
Telephone: _____
Address: _____