If you are interested in having your child join a social group at Communication Works (CW) please complete all forms and sign prior to submission. Include this checklist with your application packet and return via mail or you can drop off in person at our Center.

New/Returning Client Application Checklist

Returning clients must also complete a new application.

☐ Application
☐ Parent Questionnaire
☐ Teacher Questionnaire**
☐ Policies & Client Agreement (PCA)
☐ Notice of Privacy Practices (HIPAA)
☐ Exchange of Information
☐ A current photo- headshot preferred
☐ $60 Application Fee
   (check or money orders only)
☐ Copies of most recent assessments

**Alternate options for completing the teacher questionnaire include a counselor, coach, or mentor.

Mail Completed Application To:
Communication Works
Attn: Client Coordinator
4400 Keller Ave. Suite 200
Oakland, CA 94605

Received Applications

Once the application is received, CW will respond within one week, at which time we will either let you know of a possible opening or if the applicant will be placed on our waitlist. Incomplete applications will not be reviewed.

Placement Fee

• The $60 placement fee covers the cost of our internal review and assessment process for new clients in order to determine appropriate group placement.
• If your child is not placed in a group within three months, the $60 will be refunded.
• In the case where placement is offered but the applicant does not accept, the $60 will not be refunded.
• The process for assessing placement in a group will not be started without the $60 payment.

Insurance Policy

CW does not except insurance. However, many insurance plans will reimburse for services completed by a licensed speech and language pathologist or occupational therapist.

Our monthly invoices do provide CPT codes that insurance companies use to identify procedures. Diagnosis codes (or ICD-9 codes) can be added to invoices only when the diagnosing physician provides the code to CW in writing either by mail, email, or fax. Please contact your insurance provider directly to establish whether you are eligible for reimbursement.

Insurance Tips

Visit our Insurance Tips page: http://www.cwtherapy.com/resources/insurance-tips/

If you have questions, please give us a call at 510-639-2929.
Group Therapy Application
(7 & under)

For admin use only: ____________________

For admin use only: ____________________

TODAY’S DATE: ____________________

CLIENT INFORMATION

Name (first/last): ____________________ Gender: □ M □ F DOB (mm/dd/yy): ____________

Referred By: ____________________________ Age (yrs/mo): ____________

Services requesting or referred for:

☐ Social Group Therapy ☐ Individual Social Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Evaluation ☐ Screening ☐ Consultation

***Requested/recommended service may change based on child’s most immediate needs***

Describe any general concerns you have regarding your child: ____________________________

____________________________________________________________________________________

____________________________________________________________________________________

PARENT/GUARDIAN INFORMATION

Primary Contact (first/last): ____________________________ Relation to Client: ________________

Only list phone numbers where CW may leave confidential voice messages, and check the box to indicate your preferred method(s) of contact.

☐ Home: ______________ ☐ Cell: ___________ ☐ Work: ___________ ☐ Email: ________________

Second Contact (first/last): ____________________________ Relation to Client: _________________

Only list phone numbers where CW may leave confidential voice messages, and check the box to indicate your preferred method(s) of contact.

☐ Home: ______________ ☐ Cell: ___________ ☐ Work: ___________ ☐ Email: ________________

List other caregivers that are permitted to participate in drop off, pick up, and wrap-ups:

Name: ____________________________ Phone: ______________ Relation: ________________

Name: ____________________________ Phone: ______________ Relation: ________________

BILLING INFORMATION required

*Email: ________________________________ *all invoices are sent by email

Address: ____________________________ City: __________________ State: ______ Zip: _______

Reminder: Communication Works does not accept insurance. Insurance Tips can be found on CW’s website: http://www.cwtherapy.com/resources/insurance-tips/

REGIONAL CENTER CLIENTS If you are not a Regional Center client skip to SCHEDULE AVAILABILITY section

Have you spoken with your Case Manager about CW Services? ☐ Yes ☐ Not Yet

Case Manager (first/last): ____________________________ Phone: ________________
SCHEDULE AVAILABILITY

List the blocks of time you are available to participate in therapy for each day of the week. Write NA on days that will not work for you. **Note:** Individual speech therapy is only offered M-F before 3pm.

☐ I understand CW services run year-round (including summer) and discontinuation of services require one month’s notice. Please see Policies & Client Agreement for absence policy.

*Keep in mind that group placement involves juggling multiple schedules, ages, and needs. This is a critical part of our process in providing effective treatment. The more availability you provide the easier it will be for us to group your child.*

<table>
<thead>
<tr>
<th>Hours of Operation</th>
<th>Your availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>8am to 7pm</td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td></td>
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<tr>
<td>Tuesday</td>
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<tr>
<td>Wednesday</td>
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<tr>
<td>Thursday</td>
<td></td>
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<tr>
<td>Friday</td>
<td></td>
</tr>
<tr>
<td>8am to 4pm</td>
<td>Saturday</td>
</tr>
</tbody>
</table>

BIRTH HISTORY

Birth Weight: _______lbs. _______ oz. Number of days’ baby was in hospital after delivery: _______

Were there complications during (check all that apply):

☐ Pregnancy ☐ Delivery ☐ Post-Delivery OR ☐ Normal/ No Complications

If complications, briefly describe (e.g. weak suck nursing, vomiting, diarrhea, infections, low muscle tone):
________________________________________________________________________________________

FAMILY HISTORY/ENVIRONMENT

List language(s) spoken at home: ________________________________

Child is: ☐ Biological ☐ Foster ☐ Adopted At what age? _________

Child resides with (check all that apply):

☐ Biological Mother ☐ Foster Mother(s) ☐ Adoptive Mother(s)

☐ Biological Father ☐ Foster Father(s) ☐ Adoptive Father(s) ☐ Other: _____________________________

List sibling name(s), ages(s), and if they have medical, social, or academic concerns:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Concerns (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
List any family members who have medical, physical, speech/language, social, academic, or learning challenges:

<table>
<thead>
<tr>
<th>Relation to Client</th>
<th>Concern(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**MEDICAL HISTORY**

History of medical concerns (check all that apply):

- [ ] Feeding Problems
- [ ] Eye Problems
- [ ] Head Trauma
- [ ] High Fever
- [ ] Tonsillitis
- [ ] Chronic Colds/Respiratory Infections
- [ ] Allergies
- [ ] Asthma
- [ ] Chronic Ear Infections
- [ ] Hearing Impairment
- [ ] Temporary Hearing Loss
- [ ] Other: __________________________

Diagnoses (e.g., autism, social anxiety, attachment disorder, attention deficit disorder, cerebral palsy, sensory processing disorder): __________________________

Pediatrician: ___________________________ last seen: _____________

Hearing test:  [ ] Yes  [ ] No  If yes, when? ________________ results: ________________

Vision test:  [ ] Yes  [ ] No  If yes, when? ________________ results: ________________

List current medications: __________________________________________________________

List past medications: ______________________________________________________________________

List food allergies: _______________________________________________________________________

List special diet/dietary restrictions: ______________________________________________________________

**EDUCATION**  *If your child is not currently in school skip to CURRENT SERVICES section*

Current School: ___________________________

Type:  [ ] Preschool  [ ] Special Day Class  [ ] Regular Ed  [ ] Other _________  [ ] Aide ___% of school day

How is your child doing academically?  [ ] Excellent  [ ] Satisfactory  [ ] Poor

List any concerns your child’s teacher has expressed to you: __________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

I give consent for Communication Works staff to speak with my child’s current teacher.  [ ] Yes  [ ] No

Teacher (first/last): __________________________ Phone: __________________________
CURRENT & PAST SERVICES If your child has never received therapy services skip to DEVELOPMENT section

Please list all past and/or current therapy services your child has received, including previous CW services.

<table>
<thead>
<tr>
<th>Therapy Type &amp; Location</th>
<th>Therapist (first/last)</th>
<th>Session Frequency</th>
<th>Last seen</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Current Therapy Goals: ____________________________________________

DEVELOPMENT

I’ve noticed my child has/is (check all that apply):

☐ Not cooing or babbling       ☐ Avoiding eye contact       ☐ Restless
☐ Frequent hospitalization     ☐ Nonresponsive when spoken to ☐ Inactive
☐ Resistant to cuddling        ☐ Unusual play methods       ☐ Difficulty sharing
☐ Difficult to calm            ☐ Not gesturing (e.g., waving bye bye) ☐ Difficulty sleeping
☐ Colicky                      ☐ Not pointing or requesting ☐ Difficulty eating
☐ Separation anxiety from a parent

Did your child reach the following milestone at the typical age?

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Age in months</th>
<th>Yes</th>
<th>No</th>
<th>If No, then at what age?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pointed</td>
<td>6 – 9</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Smiled</td>
<td>3 – 6</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Sat without support</td>
<td>6 – 8</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Crawled</td>
<td>8 – 13</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Walked with assistance</td>
<td>12 – 15</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Spoke first words</td>
<td>12</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Spoke in 2 - 3 word sentences</td>
<td>18</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Eating with fingers</td>
<td>7 – 9</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Using cup/spoon</td>
<td>18 – 24</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Sipped from open cup</td>
<td>24 – 36</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Potty trained during day</td>
<td>24 – 36</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Dressed self &amp; fasteners</td>
<td>42 – 48</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Bathed self</td>
<td>72 - 78</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Brushed teeth</td>
<td>72 - 78</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
Communication Works: Group Therapy Application (7 & under)

Does your child (check all that apply):

☐ Repeat sounds, words, or phrases over and over
☐ Retrieve/point to common objects when requested
☐ Follow simple directions
☐ Respond correctly to who/what/when questions
☐ Understand what you are saying
☐ Respond correctly to yes/no questions

How does your child currently communicate?

☐ Body Language
☐ Sounds (vowels, gurgling)
☐ Words (shoe, doggy)
☐ 2 - 4 word sentences
☐ Sentences longer than 4 words
☐ Other: ____________________________

At what age did you first become concerned about your child’s physical, speech, language, and/or communication skills and why?
________________________________________________________________________________________

SOCIAL LEARNING INFORMATION

The following questions will help us get to know your child and aid with appropriate group placement. Your accuracy and honesty will help us understand each child and their needs.

Use the following scale to rate your level of concern regarding your child’s ability to:
0 = not concerned, 1 = some concern, 2 = concerned, 3 = very concerned

☐ Socialize with other children
☐ Express thoughts and ideas
☐ Pronounce words and sounds
☐ Understand and follow directions
☐ Pay attention and focus (e.g., thinking about what the group is thinking about)
☐ Regulate emotions and feelings
☐ Manage his/her body (e.g., sensory processing/personal space, seeking out roughhousing, difficulty sitting still)
☐ Use age appropriate gross motor skills (e.g., running, jumping, etc.)
☐ Use age appropriate fine motor skills (e.g., handwriting, etc.)

Check the box if you would describe your child’s temperament/characteristics as the following:
☐ Quiet, calm, relaxed, patient
☐ Active, outgoing, enthusiastic
☐ Worried, anxious, nervous, habits/tics
☐ Sad, fatigued, tired, low energy
☐ Internally distracted (e.g., preoccupied with own thoughts)
☐ May yell or hit when upset
☐ Externally distracted (e.g., preoccupied with environmental distractions)
☐ Passive, quiet, withdrawn (may hide or emotionally shut down when upset)
☐ Intense, demanding
☐ Hyperactive, always in motion
☐ Impulsive
☐ Rigid, inflexible, becomes easily frustrated
☐ Picky eater
☐ Irregular sleep patterns

Other (please describe): ____________________________

List triggers related to behavioral challenges: ____________________________
Using the following scale, rate how your child plays:

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is primarily focused on objects rather than people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriately makes eye contact with others</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Is focused primarily on their own play rather than their peers</td>
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<tr>
<td>Pretends objects are other things (e.g., a pencil is a toothbrush)</td>
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<td></td>
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<tr>
<td>Uses 3 - 4 steps in sequence when acting out play routines (e.g., mix cake, bake it, eat it)</td>
<td></td>
<td></td>
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<tr>
<td>Notices and watches peers playing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Plays next to peers (in parallel)</td>
<td></td>
<td></td>
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<tr>
<td>Initiates interactions with peers (e.g., hands them a toy, asks a question)</td>
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<td></td>
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<tr>
<td>Shares ideas with peers via conversation or play</td>
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<tr>
<td>Wants to lead the play (e.g., refuses others ideas, dictates play sequence)</td>
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<td></td>
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</tr>
<tr>
<td>Follows others interests AND ideas in play (e.g., adding a fireman to house play)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Pays attention to adults/follows an adult’s lead</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focuses on peers in play rather than adults</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Plays on his/her own with a peer for 5 - 10 minutes without adult facilitation</td>
<td></td>
<td></td>
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<tr>
<td>Takes 3 - 4 turns with peers</td>
<td></td>
<td></td>
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<tr>
<td>Independently problem solves in play (e.g., fixing a broken car, taking the boy to the doctor)</td>
<td></td>
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<tr>
<td>Has difficulty transitioning to a new activity</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Shows empathy for others</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Please answer the following questions to give us more information about your child’s strengths and challenges.

1. Tell us how your child expresses wants and needs (e.g., gestures, words, sentences, conversation, etc).

________________________________________________________________________________________
________________________________________________________________________________________

2. Tell us about how often/regularly your child understands two to three step directions and understands questions (e.g., get your monkey and put it in your bag).

________________________________________________________________________________________
________________________________________________________________________________________

3. Tell us about your child’s ability to attend to tasks or directions (e.g., playing a board game, sitting in a classroom, following steps to complete a task, etc.).

________________________________________________________________________________________
________________________________________________________________________________________

4. When watching your child around other kids, what do you notice?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

5. When watching your child in the school environment, what do you notice?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

6. Describe your child’s ability to manage their emotions (e.g., anxiety, frustration, ability to transition from activities, etc.).

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

7. Describe your child’s ability to manage their sensory system (are they hyper/hypo aware of sensory input).

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

8. Please describe any trauma your child has been through.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
9. Please provide information regarding significant family dynamics (e.g., sibling rivalry, divorce, deaths, attachments, etc).

________________________________________________________________________________________
________________________________________________________________________________________

10. What are your child’s biggest strengths?
________________________________________________________________________________________
________________________________________________________________________________________

11. What are your child’s biggest challenges and how do they affect the child and the family’s daily life?
________________________________________________________________________________________
________________________________________________________________________________________

12. List three goals you have for your child.
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

13. List some of your child’s interests and favorite activities.
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

14. Additional concerns or comments:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Dear Professional,

We appreciate your help in understanding this student's social functioning as they are seeking a social group or evaluation at our Center. **Please return this form to the student’s parent/caregiver.**

Completed by __________________________ Relationship to student __________________________
Student's name __________________________ Grade of student __________________________

Please tell us how this student performs in the following skill areas:

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows 2 - 3 step directions</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Keeps body calm when expected</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Focuses on tasks</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Watches peers play</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Plays next to peers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Initiates play with peers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Takes turns with peers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Asks for help</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Makes and keeps friends</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Keeps track of his/her materials and belongings</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Participates in classroom jobs/chores</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Shows empathy</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Understands the thoughts of others</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
Does this student stand out as unique in their social/emotional skills, either in class or out of class? If yes, please explain:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Do you anticipate that this student will encounter more challenges in future school years? If yes, please explain:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

How would this student’s peers describe him or her?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Additional Comments:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

THANK YOU!

*Alternate options for completing the Teacher Questionnaire include a counselor or coach.*
Print Client’s Name ______________________________

Fee Schedule

___ Individual Services:
  Speech, Language, Executive Function and Social Learning $118.00 per session
  Occupational (fine/gross motor, vision, sensory) $125.00 per session

___ Group Services
  Dyad (2 students) $98.00 per student
  Small Group (3+ students) $88.00 per student

___ Off-Site
  Individual Speech $125.00 per student
  Occupational Therapy $130.00 per student

Please read and initial each section.

Additional Services and Fees

On-site consultation service and other indirect services with parents, professionals and team members are billed at $118.00 per hour. Report writing, progress notes/goal summary and diagnostic therapy are billed at $125 per hour (see below for details regarding group goals and progress fees). Off-site support services, including school observations, IEP attendance and team meetings, are billed at $125 per hour for speech and social support, and $130 for OT, not including the cost of travel time ($60 per hour).

Therapy Policies

Group Placements

Clients are placed in groups with peers who are matched for cognitive, behavioral and social needs. We devote a substantial amount of time identifying the best group placement through our enrollment process; however, sometimes it is not until we see the client in the group over several sessions that we can feel confident about the placement. We typically allow a three-week trial period to ensure proper placement and to make changes if necessary. Additionally, we assess each group member’s placement throughout the year to make sure clients are in a group that is meeting their needs and not moving too fast or too slowly for their social/emotional level and development. We take this process very seriously and appreciate your understanding and flexibility with the clinical recommendation provided. Therefore, you, or your child’s group, may change to a more appropriate placement based on the needs and their therapist’s professional judgment.

Physical or Verbal Aggression

Any instance of physical or verbal aggression is reason for removal from the immediate group or individual session. A team discussion and client needs assessment will occur in order to determine if a group placement is appropriate and/or other intervention should be considered. It is imperative that sessions at CW remain a safe place for all clients. If direct assistance/support is needed for a child to stay with the group, consideration will be made regarding the client’s group readiness. Individual therapy may be needed.
Absences, Cancellations, and Discontinuations

Individual sessions are allowed three excused absences (with at least a 24 hour advance notice) at no charge per year (January to December). Additional missed sessions will be charged at 50% of the cost of the service. The three excused absences will be reinstated every January. Absences will be adjusted depending on when the client begins services. Individual sessions that are cancelled less than 24 hours in advance will be charged at 50% of the cost of the service. Excessive absences and cancellations may result in the termination of services as missing sessions impede progress and generalization of critical skills and concepts.

Clients, who need to discontinue an individual service, must provide a two-week written notice from the date of desired termination (form can be obtained from our Client Coordinator). This allows us time to wrap up with you or the client. _____

Group session progress relies on all members’ consistent attendance. However, we realize that unforeseen conflicts with scheduled sessions may occur due to illness, vacation, special events, etc. We allow for three excused absences at no charge per year (January to December). Additional missed sessions will be billed as a $50.00 fee. The three excused absences will be reinstated every January. Absences will be adjusted quarterly depending on when the client begins group services.

On the rare occasion that everyone is absent from the group except for one client, we will conduct an individual session focused on that client’s specific needs. This is an excellent opportunity for specific feedback and focus to be given to that particular client. Excessive absences and cancellations may result in the termination of services. Missing sessions impede progress and generalization of critical skills and concepts. _____

Clients who need to discontinue a group service, must provide one month’s written notice from the date of desired termination (this form can be obtained from our Client Coordinator). This allows us time to wrap up with you or the client and provide a proper transition period for all participants in the group. Due to the time spent organizing the groups we appreciate a minimum of one month’s notice. _____

Duration of Services

Individual therapy sessions are 50 minutes in length, which includes parent/caregivers training and consultation time. Parent/caregiver involvement is essential for teaching new concepts, vocabulary, newly learned skills and ways to help generalize these skills. The remaining 10 minutes of the session is utilized to analyze and report data taken during the session and to write notes pertaining to goals, progress, and parent feedback. _____

Group therapy sessions are typically 60 minutes in length. We spend 45–50 minutes with clients and the last portion (usually 10–15 minutes) with parents/caregivers for consultation and training. This training time is provided in a group or individual format depending on the needs and arrangement with the specific group. Parent/caregiver wrap-up is essential and expected for teaching the family about concepts, vocabulary, newly learned skills and ways to help generalize these skills. _____

Parent/Caregiver/School Involvement

Each client’s growth and progress depends on continued exposure and carryover to outside environments by the adults/professionals supporting the client. It is crucial for these team members to learn the concepts, vocabulary, and strategies presented in sessions. It is VERY important that parents/caregivers are familiar with these concepts and ideas and takes advantage of teachable moments outside each session. We make an effort to provide these opportunities on a weekly basis; however, for an additional fee, we are also available for consultation with parents/caregivers/teachers or team members to help with generalizing learned skills. School or outside observations are often recommended and helpful for the treating therapist to observe their clients in different environments_____
Communication Works: Policies & Client Agreement

Late Attendance
A therapy session cannot be lengthened to accommodate a client who arrives late, as we have individual and group sessions scheduled throughout the day. Clients who arrive late will be billed for the full session. 

Additional Consultation Time
Family involvement is an integral part of our services and we strive to provide ongoing communication and consultation with all family members and professionals involved with our clients. Each therapy session consists of direct treatment and a brief time at the beginning or end of the session for parent/caregiver consultation/wrap up. We support and encourage parent/caregiver to set up additional consult time outside of the allotted weekly wrap-up time as needed. Please contact your therapist for scheduling and fees involved. 

We ask that you show consideration for the client(s) scheduled after you by keeping to the allotted wrap up time for your session. In some cases, there may be a need for additional consultation time that can be scheduled by phone or email. Charges will apply to these consultation requests. 

Group Goal Summary and Progress Reports
Group sessions include a report writing policy. After the fifth session, therapists write a brief description of the group, as well as two to three individualized goals specific to each client. This will be provided to you on the sixth session. On an annual basis, therapists write a brief summary of progress toward individual goals, as well as further recommendations. These reports are a mandatory part of the overall program. For all group clients, we will bill an additional 15 minutes ($30) for goals written, and 30 minutes ($60) for annual progress report summaries on the month they are presented. 

Individual Service Assessment and Goals Development
An assessment is required for all individual clients, to determine the needs, baseline and goals of the client. If a recent assessment or progress report was performed within the past three months, it will be reviewed to determine if further testing is required. If an assessment is completed by a CW therapist, goals will be developed as part of the assessment process. If a previous assessment was completed, we will begin therapy with diagnostic therapy/observation and develop goals within the first 4-5 weeks. It is our policy that on the fifth week of services the session is reduced to 30 minutes although it is billed at the full therapy hour. The remaining 20 minutes of this session will be used for the therapist to finalize individualized goals. These goals will be presented and reviewed with you on the sixth week of services. 

Waiting Room
Parents of young clients, or those that need supervision, should stay at, or very near, the center during the session. If you feel your child is agitated or becomes easily agitated, please remain in the waiting room area. If you leave, you must leave a number where you can be contacted immediately. We expect siblings to maintain an inside, “expected” voice level while in the waiting area and to be supervised at all times. If they need to move around please feel free to take a walk or visit Skyline Pizza, Keller Market, however, make sure we have your cell phone number in case we need to call you. Help to keep the waiting area clean and clutter free by returning all items used to where they belong (i.e. books, magazines, toys, etc.). Water is available, and we ask that you do not bring outside food or drinks to the office to avoid spills, stains, and garbage. If you need to take, or make, a lengthy call on your cell phone we ask that you step outside in consideration of others in the waiting room area.
Community Outings

Community outings are extremely valuable and give the therapists good insight as to how well group members are generalizing learned concepts and skills outside of therapy sessions. Depending on the group, we try to set up community outings as much as scheduling will allow, with group members actively involved in the planning. We do not provide transportation to our destinations, but we do give families’ detailed information and have the group members actively plan the outing, which includes the day, time and directions for where the group will be meeting. Please note that by enrolling in our services you are giving permission to partake in community outings unless you make an alternate arrangement with your therapist. Outings will be billed to your account like any other session and will be reflected on your monthly invoice.

Video & Photos During Session

CW uses video and photos during sessions for therapeutic purposes only. CW will not use any videos or photos for marketing or training purposes without prior authorization.

Outside Professional Observations

CW typically does not allow outside observations during group sessions due to confidentiality and distractions. We welcome consultation and collaboration with the professionals on a client’s team. CW can then decide the best way to provide information and training for our client’s needs. This may include a site observation of the student in therapy; however, this is determined on a case-by-case basis. Volunteers and CW therapists are utilized for group support and during parent wrap-up. Confidentiality is a top priority. Please inform us, in writing, if you have concerns.

CW Mailing List

CW sends out newsletters or email announcements regarding upcoming events and information when needed. The newsletters and announcements may contain Center scheduling information, upcoming events and activities, information about the happenings at CW, and useful tips and strategies. As a client of CW, we will add your email address to our mailing list. We hate spam too and will never flood your inbox with junk mail.

Payment Policies

Invoices are sent by email at the beginning of each month for the previous month’s therapy. Payments are due immediately upon receipt regardless of whether or not you are anticipating any reimbursements from your health care provider. Cash, checks, and credit cards are accepted. Bills that remain unpaid for one month from the statement date will be subject to an additional five percent charge on the unpaid balance. Services will be suspended if there are unpaid invoices past two months without any communication to us regarding your balance. Services will be suspended until the balance is paid in full. If no communication is received and your balance is two months delayed, any outstanding invoices will be forwarded to an outside collection agency.

Communication Works (CW) is a private pay organization. We are not a participating provider with any insurance carriers and are unable to bill insurance plans directly. However, our monthly invoices provide both a billing (CPT) code and diagnosis code (if provided by the student’s physician). You can submit these invoices to your insurance provider for reimbursement. Many plans will reimburse for group therapy by a licensed speech and language pathologist or occupational therapist. Please contact your insurance provider directly to determine whether you are eligible for reimbursement. Although CW is not a participating provider with any insurance carriers, we try to support you with the necessary information on your invoices. If your insurance company requires additional documentation of service, we can do this for a nominal fee ($20 per hour).
Communication Works: Policies & Client Agreement

This Policies & Client Agreement will last for the duration of services. If an amendment is made, you will be notified and a signature of receipt will be required. You can request a copy of this agreement or any amendment at any time. Services will not begin until this agreement and other mandatory forms have been signed and returned.

I have read and agree to the above fee schedule and policies

__________________________________________________________________________  ________________
Signature of Responsible Party                                      Date
Notice of Privacy Practices

Print Client’s Name: ________________________________

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used to disclose by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose you health information.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include speech treatment.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example for this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information about treatment alternatives or other health-related benefits and services that maybe of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by representing a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2004 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, about violations of provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: Privacy Officer
Communication Works
4400 Keller Ave., Ste 200
Oakland, CA 94605
(510) 639-2929

For more information about HIPAA or to file a complaint:
The U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201
(202) 619-0257 (877) 696-6775

Signature of Responsible Party ________________________ Date ________________________
Child’s Name _______________________________ Parent’s Name _______________________________
Address ___________________________________ City ________________ Zip __________
Phone _____________________________________ Cell __________________________________________

- As you know, we provide a 10-minute wrap up period at the end of our groups for parent education and take home. This is an important part of our program; however, due to time constraints it is difficult to individualize the information and give feedback and specific impressions on each child in this period of time.

- Although we get to know each student well within the center there are other social settings that we don’t get an opportunity to observe them in. We believe that it is very important to gather information from ALL of the professionals working with your child. This can be done via a phone consultation, and gives our therapists the opportunities to see the BIG PICTURE for each child and create a supportive, connected team.

- A school observation is another great way for us to learn how your child is doing and how they are generalizing his/her skills into the school setting. This is helpful for us to get more information as well as make recommendations and support the child’s classroom teachers.

- Finally, when your child starts to work with CW, please be sure to provide us with all current relevant information such as; IEP, reports etc...

Please list the professionals you wish us to contact and let us know if you would like us to observe your child at school or do any outside training.

I, the undersigned, give permission for Communication Works to share information with any of the following professionals regarding the educational or medical treatment for my child.

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Parent/Guardian Signature __________________________________________ Date ________________

Note: On-site/phone consultations and off-site support services including: school observations, IEP attendance and team meetings are billed at different and additional rates. Off-site services may include additional travel costs.