Educational Inspiration

Child's Name: Date of Birth:

Grade Level: School:

Home Address: City, State, Zip Code

Parent name(s): Email

Parent(s) Cell Phone: Parent(s) Work Phone:

Parent(s) Place of Employment:

Name of Pediatrician: How did you hear about us?

Year of last vision screening: 20____ Pass ☐ Did not Pass ☐ _____
Year of last hearing screening: 20____ Pass ☐ Did not Pass ☐ _____

What school does your child attend?_____
Has your child ever repeated a grade? No ☐ Yes ☐ Which grade?_____
When did you first begin to have concerns about language or literacy skills?

Has the school ever provided an evaluation for your child? No ☐ Yes ☐
If yes, please explain_____
Has the school ever provided an IEP for your child? No ☐ Yes ☐
If yes, please explain_____
Has the school ever provided a 504 plan for your child? No ☐ Yes ☐
If yes, please explain_____
Has the school ever provided MTSS/RTI supports for your child? No ☐ Yes ☐
If yes, which subject?_____

Place a check next to any of the following issues that occur among parents, siblings, or grandparents:

Dyslexia/Reading Difficulties	☐	Language disorder	☐
ADHD	☐	Articulation disorder	☐
Autism	☐	Anxiety	☐
Auditory Processing	☐	Depression	☐

Did your child meet developmental milestones such as walking, talking, toileting, within expected timeframes? Yes ☐ No ☐
If no, please explain_____

Place a check next to any of the following professionals you have visited for a private evaluation:

Speech-language pathologist	☐	Occupational therapist	☐
Physical therapist	☐	Audiologist	☐
Psychologist	☐	Neuropsychologist	☐

Other:_____

Place a check if you have received any of the following:

Speech-language therapy	☐	Occupational therapy	☐
Physical therapy	☐	Reading therapy	☐
Mental wellness	☐	Vision therapy	☐

Are you currently receiving any of the above therapies? No ☐ Yes ☐
If yes, which ones?_____

What do you hope to achieve with this evaluation?

_____

What extracurricular activities does your child enjoy?

_____

What do you admire most about your child?

_____

I have been informed that a school is not required to accept findings of a private evaluation. I understand that a diagnosis does not guarantee any action/services will be provided by a school or other entity.

*Parent signature*_____ *Date*_____

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Informed Consent

I am a parent/legal guardian of the child and have carefully read and fully understand that I am giving informed consent for Educational Inspiration to evaluate my child. I have had the opportunity to discuss this evaluation with the clinician by phone and/or in person.

I understand that an evaluation is not a guarantee that a diagnosis/specific diagnosis will be given. I understand that a diagnosis does not guarantee any action or services by a school or other entity.

I understand that the evaluation will be carried out by Nicole Power, M.S., M.Ed., CCC-SLP, a licensed and certified speech-language pathologist and reading specialist. I hereby give consent to Educational Inspiration to evaluate my child.

Signature of parent/legal guardian_____

Date_____

Permission to Record Voice and Photograph Work Samples

Audio recordings as well as photographs are often utilized in the evaluation process.

Voice recordings are especially useful to aid in transcription of story retells or lengthy answer responses given during a test so they may be further analyzed. These voice recordings are destroyed once the evaluation is complete.

Photographs of work produced during the evaluation sessions are included in the final family report as evidence in support of conclusions drawn. Photos may include, but are not limited to, alphabet letters and stories. Photographs only include work samples and never include your child's image. Photographs are often saved and shared (with names removed) as part of university teaching and professional development programs.

I understand that I am giving consent for Educational Inspiration to record my child's voice and photograph work samples in order to create a well-rounded and thorough evaluation with supporting evidence. I understand that some photos of work samples (with my child's name removed) may be used as part of a professional teaching program.

Signature of Parent/Legal Guardian_____

Date_____

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Good Faith Estimate

In January 2022, the No Surprises Act went into effect. This means that as a private pay patient, you are entitled to a Good Faith Estimate. During our telephone consultation, you were informed of the services that would be provided and the cost of the service prior to booking an appointment.

- **The total cost of the evaluation is provided during the phone consultation and in the written appointment confirmation.** The fee is expected by cash or check at the first appointment.

The evaluation may include

- assessments related to speech-language, reading, spelling, and writing skills
- up to six hours of direct assessment for an initial evaluation or up to three hours of direct assessment for a re-evaluation.
- scoring of tests
- analysis of assessments, including written work samples
- compilation of results into a report provided at a family meeting. You will receive your report at the time of the meeting, approximately four weeks from the final date of the evaluation. A re-evaluation report may be significantly shorter than an initial evaluation report.

Cancellations:

- You may cancel your appointment with no charge with 48 hour notice.
- If your child is suddenly sick less than 48 hours from your appointment, you may reschedule at no charge; however, if you choose not to reschedule you will be charged a $100 fee.
- No-Shows will be charged a $200 fee.

You may contact us at 405-285-1475.

I was provided a Good Faith Estimate at least one week prior to my appointment. I have read and understand the costs and services associated with this evaluation.

Signature of parent/legal guardian_____

Date_____

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Health Insurance Portability and Accountability Act (HIPAA)

Protection of Health Information: HIPAA requires us to keep your health related information private. This includes your medical history, diagnostic evaluations, and therapeutic services.

Uses and Disclosures of your Protected Health Information: Disclosure of your health information may occur during treatment. Examples include law enforcement and voicemails/texts/emails.

Your Rights Regarding Health Information: You have the right to review your health information which might include intake and reports. Your authorization is required to send/receive information from schools or teachers.

This practice reserves the right to change/update this notice at any time. If you believe your privacy rights have been violated, submit a complaint to the US Department of Health and Human Services. I have reviewed and understand this Notice of Privacy.

Signature of Parent/Legal guardian_____

Date:_____

Text/Email Policies

Risk of using email/text/voice messages

- May be circulated, forwarded, stored, misaddressed, or sent to unintended recipients
- Back up copies may exist even after they have been deleted
- May be used as evidence in court
- Confidentiality may be breached by unintended/unknown third parties

Conditions for use of email/texts/phone calls

- Clinician uses reasonable means to maintain security and confidentiality
- Clinician is not liable for improper disclosure not caused by intentional clinician misconduct
- Families should call to discuss sensitive information rather than email/text/leave messages
- Emails or texts may be printed and saved as part of client's file
- Clinician will not forward emails/texts/voicemails without written consent

I have read and understand the policy and risks associated with use of email/text/voicemails. I consent to the use of texts/emails/phone messages between myself and the clinician.

Signature of parent/legal guardian_____

Date_____

Is the person being evaluated in high school or older? Yes_____ No_____

Acknowledgement of Testing Limitations and Diagnostic Disclaimer

- Professional Qualifications

  I have been informed and understand that Nicole Power, M.S., M.Ed., CCC-SLP is a certified speech-language pathologist and reading specialist qualified to evaluate, diagnose, and treat spoken and written language disorders, including dyslexia.

- No Guarantee of Accommodations:

  As part of this evaluation, you or your student may receive a formal diagnosis. However, it is important to understand that this does not mean that colleges, universities, licensing boards, or testing organizations (like the ACT or SAT) will grant accommodations or take any specific actions based on the results.

  Each organization has its own criteria for approving accommodations. They may require documentation from specific types of professionals or ask for additional testing or information. Because of this, it is recommended that families review and confirm the specific requirements of any college/university, testing, or licensing body they are considering prior to this evaluation to make sure this assessment will meet their needs.

- I confirm that I was informed of these limitations during consultation prior to the evaluation.

Printed Name and Signature of Parent/Guardian:

Printed Name and Signature of Student (if 18 or over):

Date: