**Speech Language Therapy Assessment Letter to New Clients**

Below is our introductory letter that we send to people who contact us for appointments and who want to know about what we do and how we operate. This letter includes our terms and conditions.  Please read through this email and the attachments, and contact me if you have any questions. It is important that you make a well-informed decision regarding our private paying service.  Please complete the forms attached to this letter and bring them into your first appointment, or return them to us by email. These forms will help us get some information from you to assist with assessment planning. If you are unable to send it back before the appointment, please let us know and your speech therapist will call you if she needs any specific pre- assessment information.

 There are two main purposes for this letter.

***1. To provide you with some pre- assessment and therapy information*** (see Form A and Form B that follow this letter)

**Initial Assessment:** The initial assessment options are either 1 hour or 1.5 hour, depending on the need of the client and the purpose of the assessment.

* Generally, a 1.5-hour assessment is for a new client who is not coming to us having had no previous speech language therapy assessment and / or needs a detailed assessment for the purpose of intervention planning or another purpose. Assessment fee for 1.5hr is $250.00, includes a brief email report
* A one hour assessment is for a client with a communication difficulty that requires a short, quick assessment, with only one obvious element of communication affected example /s/ in a lisp. Assessment fee for 1 hour is $180.00, includes verbal feedback.
* If more assessment time, or reports are needed, it will be on another day, at a cost of $35.00/15 min.

**Follow Up therapy sessions at our clinic:**

* Generally, our follow up therapy sessions are 45 min. in length at a cost of $105.
* We have found this to yield better and quicker results than 30min sessions which tend to need a longer block of therapy.  Session length will be discussed when we meet.

**Follow up therapy sessions not at our clinic (Community based therapy sessions):**

* We offer home, school and community visits as well as rest home, private hospital and work based sessions which have an add on fee depending on travel time and mileage. Travel time: $20- per 15 minutes, and mileage is 62c per km, from our base at 400 Rosedale Rd, Albany.  For community visits, therapy sessions must be paid for in advance of the session, preferably by electronic banking.

**More fee info:**

* We offer a 5% discount for fees paid in advance, for a block of 6 sessions or more.
* Fees are inclusive of GST. Fees must be paid at the time of the visit or in advance.
* Please note our EFTPOS facilities does not allow for credit card payments.
* We also accept payment is by cash, or electronic bank transfer, in advance of your session.
* Our bank details are as follows:  Account Name: Speech Therapy& Associates

Bank Acc No.: 06-0637-0203390-00       ANZ Use the client's full name as the reference

**2.  Appointment Details**

* We will discuss this with you when you are ready to make a booking.
* We agreed to an appointment as follows:

Day and Date: Start Time:

Duration of appointment: Cost of appointment:

Your speech language therapist will be:

Her phone number is Her email address is: admin@speechtherapyassociates.co.nz

**Clinic Venue:** Our clinic is at Office B4 Lovell Mews, 400 Rosedale Rd, Albany.

Please note we are NOT regularly at the Apollo clinic anymore.

**Parking:**  There is a designated visitor park available on site, across from the hairdresser. If this is full, there is additional street parking on Rosedale Rd or Lovell Court. Lovell Court is the side- street at the back of our building, and can be accessed through our parking or off William Pickering drive (Columbus Café on the corner on William Pickering, is the landmark to get into Lovell Court)

**Regular attendance and Non- attendance policy:** Regular attendance and commitment to your therapy plan is an expectation of engaging with our service. Regular attendance facilitates therapy plans to proceed in the planned and negotiated time frames. Regular attendance enhances progress to be made, and allows for skills that are learnt in therapy to be more easily generalised and maintained. There is an expectation that clients will attend at least 80% of planned sessions each month.

Please note we are a busy practice with many clients who are keen to attend short notice appointments. We therefore request that appointments are cancelled at least a day before the appointment.  Appointments that are not cancelled (also known as DNA- Did Not Attend appointments) are charged for in full, if not cancelled the day before. You will have the opportunity to attend a make-up session within 2 weeks of the DNA session.  One-day notice gives us the opportunity to offer the appointment to someone else on our wait-list. Clients who cannot attend regularly as agreed to, in their initial therapy planning session may lose their regular appointments and may be returned to our wait-list.

Please feel free to contact me by phone or email if need any further information.  We look forward to meeting you.

Many thanks

Patty Govender

Director/ Speech Language Therapist

Form A and Form B that follow on the next page

**Form A: Speech Language Therapy Assessment Information**

*The following information will be required for your first visit with us. Please complete these 4 pages and return it to us before your appointment. Please bring any relevant reports or documents that may be relevant to your appointment.*

|  |
| --- |
| Name of person needing the assessment (Client):  |
| Date of Birth: |
| Age: |
| Name of person to contact to arrange this appointment (If not the client): |
| Relationship to Client:  |
| Email address: |
| Street Address: |
| Phone Numbers: |

On what date did you complete this form?

How did you find out about us?

Tell us about why you would like an assessment with us:

Tell us about the history of this communication or swallowing difficulty and what help you might have sought for it, in the past.

Tell us about any early developmental history, medical history and family history that may be relevant to this assessment

Tell us about your school history or university history or work history that will help us understand this difficulty more holistically.

Tell us about your current situation in regard to school or university or work or home retirement. For example, what are you doing at present? How are you getting on with this? And how is the communication or swallowing difficulty impacting on you.

Tell us a little more about the client’s/ your current communication skills:

|  |  |  |
| --- | --- | --- |
| Communication Skill | Describe the skill, in your own words | Rate the skill out of 10, if 10 is no difficulty at all and 1 is very difficult  |
| The Client’s/ your level of Understanding |  |  |
| The Client’s/ your ability to express thoughts, needs and wants |  |  |
| The Client’s/ your speech clarity |  |  |
| The Client’s/ Your Voice quality |  |  |
| The Client’s/ Your Fluency or smoothness of speech |  |  |
| The Client’s/ Your hearing ability |  |  |

Add any additional information that might be relevant to this assessment here:

Please tell us there is any language, cultural or spiritual information that we need to be aware of in planning your assessment and therapy.

What would you like to achieve from this assessment and / or from speech therapy?

Name of Person completing the form:

Signed: Date:

**Form B**

**CONSENT**

**Tick and sign the appropriate box.**

|  |
| --- |
| **Adult Service****If you are seeking Speech Language Therapy service for an adult client, complete this section.*** I am the client requiring this service.
* I am the caregiver/ guardian/ spouse of this client.

I have read the terms and conditions of this service, and that I accept them.By signing below, I am confirming that I will be responsible for fees associated with this service from Speech Therapy & Associates, including fees associated with DNA (Did Not Attend) appointments.* I consent to photos and video recordings to be taken as part of the clinical intervention.
* I do not consent to photos and video recordings to be taken as part of the clinical intervention.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_Client/ caregiver Signature Print Name of client and or guardian DateIf you are completing the form electronically, please print and sign your name in CAPITAL LETTERS |
| **Child and Young Adult Service****If you are seeking Speech Language Therapy service for a child, complete this section.*** My child or ward is requiring this service.
* I am the parent or legal guardian of the child requiring this service.

 I have read the terms and conditions of this service, and that I accept them. By signing below, I am confirming that I will be responsible for fees for this child, associated with this service from Speech Therapy & Associates, including fees associated with DNA (Did Not Attend) appointments. * I consent to photos and video recordings to be taken as part of the clinical intervention.
* I do not consent to photos and video recordings to be taken as part of the clinical intervention.

If I do not attend some or all the speech language therapy sessions with my child, I give consent for the staff at Speech Therapy Associates to engage with:* Teachers at my child’s school/ kindergarten
* Nanny/ Au Pair/ child minder
* Grandparent/ other family member.
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_Parents/ Guardian’s Signature Print Name of parent or guardian DateIf you are completing the form electronically, please print and sign your name in CAPITAL LETTERS |