APPLICATION

Patient Information:

Child's name _____ Date of birth: _____

How was your child referred to the Sertoma Speech Clinic? _____
_____

Name of Health Insurance Provider: _____

What type of coverage does your health insurance offer for speech evaluation or therapy? (if you are unsure, please call your insurance company and ask)
_____

Mother Information	**Father Information**
Name:	**Name:**
Address:	**Address:**
City, State, Zip:	**City, State, Zip:**
Daytime phone:	**Daytime phone:**
Cell phone:	**Cell phone:**
Email address:	**Email address:**

Person completing application:_____
How many children are living in your home? _____
Child is living with _____

Financial Information

Mother	**Father**
Employer:	**Employer:**
Address:	**Address:**
Phone:	**Phone:**
Position:	**Position:**
Gross Monthly Income:	**Gross Monthly Income:**
Savings	**Savings**

Other Monthly Income

Alimony:	**Child Support:**
Commissions:	**Rental Income:**
Disability:	**Interest:**
Pension:	**Stocks**
Shared Living:	**Other:**

Assets: (Please list year/make of automobiles, motorcycles, recreational vehicles, etc.)

Financial Liabilities/Monthly Expenses

	Monthly	Balance
House/Apartment		
Car Payment/Lease		
Loans (non credit cards)		
Medical/Dental		
Child Care		
Gas/Transportation		
Groceries		
Insurance – Auto/Life		
Insurance – Health		
Utilities		
Totals		

Note: All information supplied herein will remain part of the confidential records of the Sertoma Club of Greater Sarasota and will not be distributed to or released to anyone outside organization or agency for any reason.

I certify that the information contained in this financial review and assistance request is true to the best of my knowledge. I further understand Sertoma may verify any of the above information. I grant my permission for such verification, and agree to assist in any way requested. I understand that Sertoma Club of Greater Sarasota reserves the right to cancel my assistance and collect full fees for services in the event of fraudulent financial status while involved with the program.

_____ _____

Signature Date

Therapy Guidelines

1. Attendance is important to meet your child's speech goals. Inconsistent attendance will lead to slow progress.

2. Your child will be discharged from therapy if he/she misses more than 50% of the scheduled sessions per month. Excused absences include: illness, doctor's appointment, vacation, and family emergency, therapist cancellation, and car problems.

3. You are responsible to pay for a missed therapy session if it is not an excused absence.

4. If you need to cancel your appointment, please call your therapist as soon as possible.

5. Payment is due the day that the therapy is rendered.

6. Please sign in on the attendance sheet upon arrival.

7. Please be on time to your child's appointment so that other children in the group are not disrupted and therapy time lost.

8. Please stay in the waiting area until your therapist comes to get you and your child for therapy. An adult caregiver must remain in the building for the entire time your child is in therapy.

9. Please do not bring your child to therapy with a fever or a contagious condition (chicken pox, lice, pinkeye, a green runny nose, cough, etc.)

10. When your child's therapy session is complete, your therapist will be available briefly to discuss your child's progress. Please refrain from cell phone use during this time and be mindful of her time as she begins another therapy session.

Please sign below that you have reviewed and agree to the following guidelines. We look forward to working with you and your child.

_____
Child's name

_____ _____
Parent/Guardian Signature Date