Client's Name:
Assigned Therapist:

the emerge CENTER

for communication, behavior, and development

Initial Enrollment Packet

7784 Innovation Park Drive
Baton Rouge, LA 70820

225-343-4232 Fax 343-4233

www.emergela.org

United Way Member Agency

Date Scanned & Entered Into Chart: _____ Initials: _____

Emergency Information Sheet

Child's Name: _____

In case of emergency, who do we call first? Mother Father Contact Person #1 #2

Parent Information

Mother's Name _____ Preferred Phone: _____

Alternate Phone _____ Work Phone: _____

Parent Email:_____Additional Info/Notes: _____

Father's Name: _____ Preferred Phone: _____

Alternate Phone: _____ Work Phone: _____

Parent Email:_____Additional Info/Notes: _____

Please list two additional emergency contact people:

Contact Person #1

Name _____

Address: _____

Phone _____

Relationship _____

Contact Person #2

Name _____

Address _____

Phone _____

Relationship _____

In the event that a parent or designated contact person cannot be reached, I/we hereby authorize The Emerge Center to secure emergency medical treatment for my child.

_____

Signature(s) of Parent(s) or Legal Guardian(s)

If it is necessary to secure emergency medical treatment, my child's pediatrician is:

Doctor's Name _____

Office Phone _____ Additional Phone _____

Office Address _____

Child "Pick-Up/Release" Policy

For the safety of your child, as well as that of The Emerge Center, he/she cannot and will not be released into the custody of, or allowed to be picked up by, anyone other than the person or persons designated in writing by you. This person must be an adult at least 18 years of age. As an added precaution, if the person picking up your child cannot be identified by staff as an officially designated pick-up person, a request for identification may be made. Please inform your designated pick-up people that identification may be required so that they are prepared, rather than insulted. In such a case, it is better to be safe and risk insult than it is to be wrong and compromise the safety of the child.

In addition, it is your responsibility to keep your designated pick-up list current. Any revisions to your official list, whether it be to add to or delete from, must be in writing prior to the anticipated date of change.

Understanding this, I/we authorize the following people to pick-up my/our child from the Emerge Center:

Name	Relationship	Date of Authorization	Date Withdrawn

_____

Child's Name

_____ _____

Parent/ Guardian Signature Date

Allergy Alert

Child's Name _____ Date_____

Person completing this form _____Relationship to Child _____

Does your child have any known allergies?☐YES☐NO

To foods☐YES ☐NO

If yes, please list food, allergic response, and necessary treatment:

_____

To medications☐YES☐NO

If yes, please list medication, describe the allergic response, and necessary treatment.

_____

Other allergies☐YES☐NO

If yes, please list, describe allergic response, and necessary treatment

_____

Are there any other/additional foods that you prefer your child NOT to have?☐YES☐NO

If so, please list:

_____

_____

_____

_____ _____

Parent/ Guardian Signature Date

Photo/Video Release Form

The Emerge Center occasionally photographs & videos our services for use in educational, promotional & fundraising materials in print and online (including our website, Facebook, Twitter, YouTube, and our blog).

We never include a patient/client's name with his/her picture/video, unless we have express permission.

Please choose one level of permission pertaining to photos/videos of you/your child:

____ Emerge has the right to use any photos/videos of me/my child receiving services at their discretion.

____ Emerge may never use any photos/videos of my child.

Signed: _____

Printed Name: _____

Child's first & last name: _____

Date: _____

Therapist: _____

Group/Time: _____

Consent for Assessment and Treatment

Client Name _____ Client Date of Birth _____

I voluntarily consent to the assessment and the treatment offered by the Emerge Center. I give my permission for the staff of the Emerge Center to perform the following service(s):

Testing/ assessment and/or treatment from staff of the Emerge Center in the following departments:

☐ Speech Therapy assessment and/or treatment

☐ Audiology Services

☐ Psychological assessment and/or treatment

☐ Applied Behavior Analysis therapy

☐ Occupational Therapy assessment and/or treatment

☐ Specialized consultation:_____

☐ Other: _____

This consent is for
☐ Myself
☐ My family member (Name _____)
☐ Other (Explain: _____)

I have been informed that I, my family member, or the interdict will receive testing and/or treatment from Emerge Center. These procedures may involve, but are not limited to: tests of cognitive, speech/language, perceptual, physical, memory, and social/emotional functioning. I understand that during the interview-intake process, I will be asked about the symptoms and history related to my, my family member's, the interdict's present problem. I have been informed about confidentiality and its limits.

Further,
• I understand that services will be provided by employees of the Emerge Center and its Contractors and that, upon my signature, my, my family member's, the interdict's confidential information may be discussed among Emerge Center employees in pursuit of the highest quality of assessment and/or treatment.

• I understand that this consent may be rescinded or modified at any time with a written request to the Emerge Center.

• I understand that these services may include direct, face-to-face contact, interviewing, records review, consultation with other professionals, and other related activities necessary to support these services.

• I understand that there will be no exchange of printed or verbal information outside the Emerge Center without an appropriate release of information that I review and sign.

• I understand and agree to, for professional training purposes, supervised students observing and/or participating in the rendering of my, my family member's, the interdict's services.

• As part of the student/clinician training process, for reasons related to safety, and/or for consultation with other professionals under Emerge Center, I understand and agree to the live monitoring or taping for review upon a later date as needed, the video recording of the provision of services for which I am herein providing my consent.

- I understand all information client information strictly confidential. The legal exceptions are:
    - The client, parent/guardian or legal representative authorizes a release of information with a signature
    - To comply with a court order
    - There is suspicion of abuse or neglect involving a child, elder, or vulnerable person.
    - The client presents as a danger to self or others
    - Record review as requested by insurance carrier provided authorization has been obtained.

I give my permission and consent for assessment and/or treatment.

_____ _____
Signature of Individual or Personal Representative by Law Date

_____
Personal Representative's Relationship/Authority

_____ _____ _____
Signature of Emerge Center Representative Date

NOTE: If the individual is a competent major, he or she is to sign, or make his or her mark on the first line. If the individual is a minor, incompetent major, or unable to sign, the parent, guardian, or correspondent is to sign on the first line and fill in the second line.

Patient Easy Pay Consent

I authorize

_____ to

(Name of Health Care Provider)

maintain my credit/debit on file for the balance of charges not paid by insurance within 90 days.

Not to exceed $_____

☐ Weekly ☐ Semi-Monthly (1st and 15th) ☐ Monthly (1st of the month)

Date(s) of Service _____/_____ to _____/_____

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

_____ _____

Cardholder Signature Date

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Card Number: _____-_____-_____-_____ Exp. Date: _____/_____ Security Code: _____

Circle One: Visa / MC / AMEX / Discover Email Address: _____

Primary Phone: _____ Secondary Phone: _____

Please return to:
Emerge Center Accounting
accounting@emergela.org
7784 Innovation Park Drive, Baton Rouge, LA 70820

Below to be completed by The Emerge Center staff

Patient Acct # _____

Research Database at the Emerge Center
Description and Consent Form:

The Emerge Center Research and Design Department is dedicated to validating and sharing the good work we do here at Emerge through evidence based research and high quality peer, reviewed publications! We also coordinates research projects with outside research groups such as LSU Department of Communication Science and Disorder and LSU Department of School Psychology.

We anticipate having the opportunity to recruit participants for more studies in the near future. If you would be interested in having your child participate in these studies, please complete the information below and you will be added to the Emerge Center Research Database. The information you provide will be kept confidential and not shared with outside researchers. Instead, the Emerge Center Department of Research will email you when research opportunities occur, allowing you to decide whether or not to participate. Your decision to participate or not in a study will never impact the therapies that you receive at the Emerge Center.

If you have any questions please contact Dr. Jane Morton, Director of Research and Design at jmorton@emergela.org or 225-663-6932. You may remove your name from the Emerge Center Research Database at any point by emailing Dr. Morton as well.

Emerge Center Research Database Consent Form
(Please complete and return to the front desk.)

Child's name: _____ Child's date of birth: _____

Would you be willing for your child's name to be added to the Emerge Center Research database? This information will be kept confidential and used only when future research opportunities arise. ☐ Yes ☐ No

Does your child have a diagnosis of Autism Spectrum Disorder? ☐ Yes ☐ No

Does your child have a diagnosis of Apraxia? ☐ Yes ☐ No

Parent's name: _____
Parent's preferred phone number: _____
Parent's email address: _____
Parent signature _____ Date _____