THESE FORMS
MUST BE COMPLETED
BEFORE YOU ARRIVE FOR
YOUR APPOINTMENT

104 W. Spinner Road
DESOTO, TEXAS 75115

**PHONE:** (972) 900.9730
**FAX:** (972) 767.0044
www.pryorandassociates.com

Enclosed are documents that need to be completed prior to the evaluation of you or your student's (client) learning problems. If school or private testing has been done in the past, please bring the results to us on the day of your appointment along with the enclosed documents. ***We will also need the client's most recent grade reports, transcripts and copies of standardized testing (i.e., STAAR, Stanford Achievement Test, Benchmark/District-wide Assessments and Iowa Test of Basic Skills (ITBS).***

## Frequently Asked Questions

1) **How many times will the client come for testing?**
   The evaluation is usually a one to two visits, depending on individual circumstances. The client will be tested during the first 1-2 appointments. No results are available after the first appointments. The last appointment is when I will visit with parents, students, etc. to discuss the results and share recommendations.

2) **About how long will the appointments take?**
   Testing Appointment: Depending on the client's needs, these appointments can take up to 3 hours. (Some Saturday appointments are available on a first come first serve basis)

   Last Appointment/Clinical Review: Discussion of test results and recommendations usually last from 45 to 90 minutes. We recommend that you schedule at least two hours for this appointment in case of delays.

3) **How should I prepare for the visit?**
   Tell your child there are no objects that will hurt them at the office where they will be tested. Your child should know that the purpose of the testing is to find out what makes school hard. He will do school work in a room with a nice learning specialist. Encourage your child to do their very best work.

   Be sure the child or the person being assessed has eaten a good meal before the visit. We want them to be at their best during the evaluation. Most children are unable to perform well when they are hungry.

   Wear comfortable clothes that are right for the temperature. Since the temperature changes in Texas so quickly, they should bring a sweater or jacket even if it is supposed to be warm outside.

4) **Can I watch while my child is being tested (if under the age of majority)?**
   No. There are strict testing guidelines that prohibit parent observation.

5) **Will I be given the test results and recommendations the same day of the evaluation?**
   No. I will need time to score and analyze the test results and will use the test results, information from the school and all the information you have provided to make a diagnoses and develop recommendations. The diagnoses and recommendations will be shared with you or the client during your final appointment.

   ***Note: There is usually 2-3 weeks between your evaluation appointment(s) and your final consultation appointment. No part or section of the final report or diagnosis will be given prior to your final appointment. Please plan accordingly.***

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**6) Should I/my child or student take all regular medications before testing?**

Absolutely. This will be our only opportunity to evaluate you or your child. It is important that we see the best academic performance during the testing in our offices. *Make sure you or your child takes the same medications at the usual times he or she would during the regular academic year.* The medication should be taken even if the testing is done during summer vacation, spring break or a school holiday. If you have questions, please call prior to the first appointment.

**7) What should I/we bring to the testing appointment?**

A **Parent Questionnaire** and a **Teacher/Instructor Questionnaire** were picked up by you or sent to you via US mail. You will need to bring these to the first appointment. Please make sure that these are completely filled out. If your child or the client has had any new testing in school, please bring copies of this information. This information helps us to design an even more specific evaluation.

Bring you or your child's most recent report card/transcript.

If your child is under the age of majority (18 years in Texas), you will need to remain in the facility during the testing appointments. You may want to bring a good book or a project along. If you feel that you or your child might require a snack or beverage during their break in testing, please bring a small snack on the day of testing. If you forget your smack, the facility has some snacks available at a minimal cost.

**8) Who should come with my child (under 18 years)?**

During the testing appointments, we require that at least one parent come with the child. **It is necessary that parent will be required to remain in the facility during the testing appointments and/or therapy.**

***Both parents*** should come to the final appointment since this is when we will discuss the diagnosis and recommendations. Although it would be beneficial for your older child (12 & over) to come to all appointments, it is not required that he or she be present at the final appointment during the review of the diagnosis and recommendations.

**9) What if we are not able to keep our appointment?**

Notify the office **within 72 hours of your *evaluation* appointment** by calling 972.283.7900. You may also email at rosalynpryor@pryor and associates.com. There is a $25 charge per day if appointments are cancelled within 72 hours of the scheduled appointment.

**24 hours notice is required for the cancellation of therapy appointments and consultations. If you are going to be more than 5 minutes late for an appointment, please contact your therapist immediately.**

**10) What if my check is returned for insufficient funds?**

In the event that your check payment is returned for insufficient funds, please notify our offices immediately. For all returned checks, your account will be charged $35. All future clinical services must be paid by money order or cashier's check payable to Pryor & Associates.

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# REQUEST FOR REFERRAL

**Referred To:** **Pryor & Associates**
**Counseling and Diagnostic Center**
104 W. Spinner Road
Desoto, Texas 75115
Phone: 972.900.9730
Fax: 972.767.0044
www.pryorandassociates.com

**Patient:**_____ **is referred for a (an):**

| **Assessments:** | **Therapy / Intervention:** |
|---|---|
| ☐ Speech-Language Evaluation | ☐ Speech-language Therapy |
| ☐ Counseling Evaluation | ☐ Cognitive-Linguistic Retraining |
| ☐ Psychoeducational Evaluation (academics) | ☐ Counseling (Individual or Group) |
| | ☐ Social Skills Training |

**Medical Diagnosis (include codes if known):**_____

**Patient complaints or symptoms:**_____

_____ _____
**Signature of Primary Care Physician / Referring Physician** **Date**

_____
**Name (Please Print)**

_____
**Address** **City** **State** **Zip**

_____ _____
**Phone** **Fax**

American Speech-Language-Hearing Association

Certified by the American Speech-Language Hearing Association and
the State Board of Examiners for Educator Certification (SBEC) as an Educational Diagnostician

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# CONSENT FOR EVALUATION

| | | | | | |
|---|---|---|---|---|---|
| **Name:** | | **Grade:** | | **Birth Date/Age:** | |
| **Address:** | | **School:** | | **Home Phone:** | |
| **Parents/Guardians:** | | **Work Phone:** | | **Cell/Mobile Phone:** | |

**We need your permission to assess you/your child to establish the educational needs and/or learning differences. Please check the appropriate boxes, sign your name and date with today's date.**

| | | |
|---|---|---|
| | | **I have been fully informed of the evaluation process.** |
| **YES** | **NO** | |
| | | |
| | | **I give my permission for the assessment of my child/me.** |
| **YES** | **NO** | |
| | | |
| | | **I understand that my consent for evaluation is voluntary.** |
| **YES** | **NO** | |

**Signature of Patient (if age of majority)** **Date**

**Signature of Patient/Legal Guardian/Surrogate Parent** **Date**

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**AUTHORIZATION FOR TREATMENT**

I, the undersigned, do hereby consent to and authorize all diagnostic and therapeutic treatments/assessments considered necessary of advisable in the judgment of the clinician in charge of my (my child's) care.

I acknowledge that no guarantees have been made to me as to the results of treatment, examination or assessment.

**ASSIGNMENT OF INSURANCE BENEFITS**

I assign to Pryor & Associates, Oran L. Pryor, MA, LPC or Rosalyn R. Pryor, MS, CCC-SLP any money payable to me under insurance for such services up to the total amount owed. I understand that I'm responsible for the total charges incurred, and agree to pay any amounts due that are not paid by any insurance company's, Employee Assistance Program's, or third party's arbitrary determination of usual and customary rates.

**RELEASE OF INFORMATION**

I HEREBY AUTHORIZE Pryor & Associates, Oran L. Pryor, MA, LPC or Rosalyn R. Pryor, MS, CCC-SLP to release any necessary information acquired in course of my assessment, examination or treatment to, insurance carriers, attorneys, governmental agencies, or others who are financially liable for my medical care; all information needed to substantiate payment for such services and to permit representatives thereof to examine and make copies of all records relating to diagnostic and therapeutic treatments.

**BILLING PROCEDURES**

I understand that the bill from Pryor & Associates, Oran L. Pryor, MA, LPC or Rosalyn R. Pryor, MS, CCC-SLP only includes charges for services rendered and the use of equipment and supplies.

**THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE FOREGOING, AND IS THE CLIENT OR PARENT/LEGAL GUARDIAN OF THE CLIENT OR IS DULY AUTHORIZED BY THE CLIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.**

**CLIENT AND/OR FAMILY MEMBER IS AWARE OF THE IMPORTANCE OF MAINTAINING APPOINTMENTS. THE PATIENT AND/OR FAMILY MEMBER IS ALSO RESPONSIBLE FOR ANY WRITTEN INSTRUCTIONS AND/OR EQUIPMENT GIVEN OUT DURING THERAPY OR AN EVALUATION / ASSESSMENT AND FAILURE TO FOLLOW THROUGH WITH INSTRUCTIONS MAY LEAD TO SLOW PROGRESS.**

_____ _____
**Client's Signature (if of majority age)** **Witness**

_____ _____
**Client's Agent / Parent / Legal Guardian Signature (if applicable)** **Relationship to client**

_____
**Date**

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## AUTHORIZATION TO OBTAIN MEDICAL / EDUCATIONAL RECORDS

**NAME (LAST, FIRST, MIDDLE INITIAL):** _____

**PARENT / LEGAL GUARDIAN:** _____

**STREET ADDRESS:** _____
**CITY** **STATE** **ZIP**

**DATE OF BIRTH:** _____ **SSN:** _____

**I hereby authorize:**

_____
**NAME OF COMPANY / INDIVIDUAL / SCHOOL / DISTRICT**

_____
**STREET ADDRESS** **CITY** **STATE** **ZIP**

**to release to Pryor & Associates Counseling and Diagnostic Center, photocopies of medical records, psychological information, and educational records for the purpose of review and examination. I understand that the specific information to be released may include, but is not limited to medical history, diagnosis, psychological information, special education records, general educational records, mental/psychiatric related illness, or communicable disease.**

_____ _____
**Patient's Signature (if of age of majority)** **Date**

_____ _____
**Patient/Legal Guardian's Signature** **Date**

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# AUTHORIZATION TO RELEASE MEDICAL / EDUCATIONAL RECORDS

**CLIENT INFORMATION**

| | | |
|---|---|---|
| **NAME:** | | **I hereby authorize:** |
| **STREET ADDRESS:** | | **PRYOR & ASSOCIATES**<br>**COUNSELING AND DIAGNOSTIC CENTER**<br>104 W. Spinner Road<br>DESOTO, TEXAS 75115<br>PHONE: 972.900.9730<br>FAX: 972.767.0044 |
| **CITY, STATE, ZIP** | | |
| **PHONE:**_____ | | |
| **FAX:**_____ | | |
| | | **to disclose information regarding my/my child's treatment, medical and/or behavioral health condition to the following professional person/agency and/or facility:** |

_____
Name of Professional Person/Agency

_____
Address City State Zip

_____
Phone Number Fax Number

_____
Email Address:

| **INFORMATION TO BE RELEASED OR EXCHANGED INCLUDE: THE AUTHORIZED PURPOSE(S) FOR THIS RELEASE ARE:** | **THE AUTHORIZED PURPOSE(S) FOR THE RELEASE ARE:** |
|---|---|
| **_____ EVALUATION/ASSESSMENT REPORT**<br>**_____ TREATMENT PLAN**<br>**_____ PROGRESS NOTES**<br>**_____ DISCHARGE AND SUMMARY**<br>**_____ BEHAVIORAL HEALTH TREATMENT/RECORDS**<br>**_____ OTHER :) _____** | **_____ DIAGNOSIS AND TREATMENT**<br>**_____ COORDINATION OF CARE**<br>**_____ INSURANCE / PAYMENT PURPOSES**<br>**_____ OTHER:_____** |

I understand that my/my child's health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or sixty (60) days after I completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me and I signed it of my own free will on:

The _____day of _____, 20_____.

_____ _____
**CLIENT'S SIGNATURE (IF AGE OF MAJORITY)** **DATE**

_____ _____
**PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE, IF REQUIRED** **DATE**

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# NOTICE OF PRIVACY PRACTICES

Last Update: 11-01-2006

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information. PLEASE REVIEW IT CAREFULLY.**

## OUR PLEDGE REGARDING MEDICAL INFORMATION:

Staff at Pryor & Associates Counseling and Diagnostic Center creates a record of the care and services you or your child receive(s) at PACDC and uses this record to provide you or your child with quality care as well as to comply with legal requirements. Because we understand that information about your or your child's health is personal, we are committed to protecting that information, whether it is in written, verbal or electronic format.

This notice, which is required by law, describes the practices of Pryor & Associates with respect to your or your child's protected health information. It applies to all records of your or your child's care generated by Pryor & Associates.. All Pryor & Associates staff, counselors, and clinicians who are authorized to have access to your or your child's health information are subject to the provisions of this Notice.

We are required by law to:
I. Abide by the terms of the Notice that is in effect at a given time.
II. Protect the privacy of your or your child's health information.
We will not use or disclose your or your child's health information without authorization, except as described in this Notice.
For each type of use or disclosure, we will explain what we mean and try to give some examples. Not every use or disclosure will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the following categories:

## USE AND DISCLOSURE OF YOUR OR YOUR CHILD'S HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION:

**For Treatment:** While we are providing you or your child with health-care services, we may need to share your or your child's health information with other health-care providers or other individuals who are involved in providing health care to you or your child. Examples include doctors, hospitals, nurses, therapists, and labs that are involved in your or your child's care, whether inside or outside Pryor & Associates.

**For Payment:** Pryor & Associates may need to share health information about you or your child to help us with such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance provider for payment.

**For Health Care Operations:** Pryor & Associates may need to share health information about you or your child in the course of conducting health-care business activities that are related to providing health care to you or your child. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you or your child. We may also combine health information about many clients to decide what additional services we should offer, what services are not needed, and whether certain new services are effective.
**Treatment Alternatives and Appointment Reminders:** We may use your health information to remind you of services, treatments, or scheduled appointments.

**Business Associates:** There are some services provided at Pryor & Associates through contracts with business associates such as medical transcription and computer software services. We require business associates to protect your or your child's health information.

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**Individual Involved in Your Care or Payment for Your Care:** Unless you notify us that you object, we may release health information about you or your child to a friend or family member who is involved in your or your child's medical care.

**To Avert a Serious Threat to Health or Safety:** As required by law, and standards of ethical conduct, we may release your or your child's health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to anyone's health or safety.

**Military, Veteran, National Security, or Incarceration / Law Enforcement Custody:** We may be required to release your or your child's health information to the military or for national security or intelligence activities or if you are in the custody of law enforcement officials.

**Public Health Activities:** We may be required to report your or your child's health information to authorities to help prevent or control disease, injury or disability.

**Health Oversight Activities:** We may be required to release health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in health care, or for governmental benefit programs.

**As Required or Allowed By Law:** Sometimes we must report some of your or your child's health information to legal officials or authorities such as law enforcement officials, court officials or governmental agencies or attorneys.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD:** Although your or your child's medical record is the physical property of PACDC, the information belongs to you. You have the following rights regarding medical information we maintain about you or your child:

**Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your or your child's care as provided by law. Usually, this includes medical records, but does not include psychotherapy notes. If you wish to inspect and copy medical information that may be used to make decisions about you or your child, you must submit your request in writing to the Pryor & Associates Medical Records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

**Right to Request an Amendment:**
If you feel that medical information we have about you or your child is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to Pryor & Associates' Medical Records. We will notify you if we are unable to grant your request to amend the record.

**Right to Obtain an Accounting of Disclosures:** You have the right to obtain an accounting of disclosures made of your or your child's protected health information as provided by law. Requests for such accounting can be made to the Pryor & Associates Medical Records.

**Right to Request Restrictions:**
You have the right to request a restriction on the medical information we use or disclose about you or your child for treatment, payment or health care operations and as to disclosures permitted to persons including family members who are involved in your or your child's care or the payment for your or your child's care as provided by law. However, we are not required by law to agree to a requested restriction and will notify you if we are unable to agree to the requested restriction. If we do agree, we will comply with your request unless the information is needed to provide you or your child emergency treatment. To request restrictions, you must make your request in writing to the Pryor & Associates Privacy Officer.

**Right to Request Confidential Information:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests and will not ask you the reason for your request.

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**Right to Revoke Authorization:** If you have provided us with authorization to use or disclosure medical information about you or your child, you have a right to revoke that authorization except to the extent that action has already been taken in reliance on your authorization.

**CHANGES TO THIS NOTICE:**
We reserve the right to change our practices and to make the revised or changed provisions effective for all protected health information we maintain. You may request a copy of the current notice by writing to the Pryor & Associates Privacy Officer, or by requesting a copy from the Pryor & Associates staff when you visit the center for an appointment. The revised notice will also be posted at the center. The effective date of the notice will be on the top right hand corner of the first page.

**COMPLAINT: If you believe your or your child's privacy rights have been violated, you can file a complaint with PACDC or with the Secretary of the Department of Health and Human Services. Complaints may be submitted in writing to the:**

**Privacy Officer**
Pryor & Associates Counseling and Diagnostic Center
104 W. Spinner Road
Desoto, Texas 75115

**Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:**

Print Client's Name:_____

Client's Signature (if of majority age):_____

Print Parent/Legal Guardian's Name:_____

Parent/Legal Guardian's Signature:_____

Date:_____

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## Release of Records to Patient or Parent/Legal Guardian

I acknowledge that my records were released to me by Pryor & Associates, Oran L. Pryor, M.A., LPC, or Rosalyn R. Pryor, M.S., CCC-SLP at my request. I release Pryor & Associates, Oran L. Pryor, M.A., LPC, and Rosalyn R. Pryor, M.S., CCC-SLP from any and all liabilities that may result from receiving these records.

_____ _____
Client's Name (print clearly) Date

_____ _____
Client's Signature (if of legal majority age) Date

_____ _____
Parent/Guardian's Name (print clearly) Date

_____ _____
Parent/Guardian's Signature (if applicable) Date

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# Vision and Hearing Screening Results

***TO BE COMPLETED BY THE SCHOOL NURSE, Audiologist and/or PRIMARY HEALTH CARE PROVIDER***

| | | | | | |
|---|---|---|---|---|---|
| **Student Name:** | | **Grade:** | | **Birth date:** | |
| **Address:** | | **School Name:** | | **Home Phone:** | |
| **Parents/Guardian:** | | **Work Phone:** | | **Cell/Mobile Phone:** | |

**VISION**

Date of most recent screening:_____ Type of screening:_____
Name and position of person conducting screening:_____

| | |
|---|---|
| ☐ **Within Normal Limits**<br>○ without glasses<br>○ with glasses | ☐ **Not Within Normal Limits**<br>(See report from ophthalmologist or optometrist) |

| | | |
|---|---|---|
| | | As a result of the screening, is there any indication of a need for further evaluation or adjustment? If yes, explain: |
| Yes | No | |

| | | |
|---|---|---|
| | | Has any follow-up treatment been recommended? If yes, explain: |
| Yes | No | |

**HEARING**

Date of most recent screening:_____Type of screening:_____
Name and position of person conducting screening:_____

| | |
|---|---|
| ☐ **Within Normal Limits**<br>○ unaided<br>○ aided | ☐ **Not Within Normal Limits**<br>(See report from otologist or audiologist) |

| | | |
|---|---|---|
| | | As a result of the screening, is there any indication of a need for further evaluation or adjustment? If yes, explain: |
| Yes | No | |

HEALTH

| | | |
|---|---|---|
| | | DOes this student exhibit any signs of health or medical problems? If YES, explain: |
| Yes | No | |
| | | Is there a need for further assessment or referral of a medical problem? If YES, explain: |
| Yes | No | |
| | | Is the student receiving any medication at school? If YES, specify: |
| Yes | No | |
| | | Does this student require adaptive equipment or facility adaptation? If YES, specify: |

_____ _____ _____
Signature of Person Completing This Section Position Date

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Referrals for Hearing Screenings

1. Your child's school nurse. In most cases, schools perform vision and hearing screenings for students at least once per year. You can provide a copy or have the nurse complete the form on the preceding page.

2. Dr. Barbara J. Parker, Ph.D.
   Hearing Solutions
   2715 Bolton Boone
   Desoto, Texas 75115
   972.572.5582

3. Childrens Medical Center – Dallas
   214-456-6862

4. Childrens Medical Center – Plano
   469-303-4700

5. Callier Center for Communication Disorders
   1966 Inwood Rd, Dallas, TX 75235
   (214) 905-3000