



Services for: \_\_\_\_\_ On: \_\_\_\_\_ At: \_\_\_\_\_

- BABY UNIVERSITY**  
Developmental milestones are tracked and supported in this wonderful class, nick-named “Baby University”. With a three to one ratio, these little ones are immersed in a language rich environment. Tumbling Tutor and Music Together are icing on the cake.
- AVALON PRESCHOOL**  
Avalon provides a language rich environment and developmentally appropriate instruction that facilitates emergent social, motor and language skills. We utilize the fundamentals of speech and language and cognitive development to guide young learners to their strengths and guide them through their weakest areas.
- SPEECH and LANGUAGE EVALUATION**     **ARTICULATION EVALUATION**
- SPEECH THERAPY**  
Speech Therapy targets receptive and expressive language skills including vocabulary, listening comprehension, following directions, pragmatics, oral and written expression. Speech Therapist at Central Coast Language and Learning Center provide individuals and their families with strategies and solutions for resolving communication difficulties.
- OCCUPATIONAL THERAPY EVALUATION**
- OCCUPATIONAL THERAPY**  
Occupational Therapy focuses on refinement of sensory integration, development of fine and gross motor skills, self-regulation, and age appropriate self care skills
- EDUCATIONAL EVALUATION**  
A full educational evaluation helps the client learn how he or she learns best. If learning is more difficult, frustrating, or time consuming than others, CCLLC can evaluate a student’s developmental learning profile and make recommendations for appropriate instruction. Our evaluations are based on a battery of tests that assess cognitive skills and processing, academic skills, language development and behavioral issues related to learning. Evaluation is essential in planning an instructional program for those who learn differently.
- EDUCATIONAL THERAPY**  
Educational Therapy is individualized instruction that utilizes information from the client’s social, emotional, and educational history to remediate learning difficulties. Educational Therapists at Central Coast Language and Learning Center are trained to facilitate cognitive, language, academic and behavioral skills and strategies.

Services to be provided by: \_\_\_\_\_

Payment accepted: MC/Visa, or by check payable to: CCLLC

Total fee for this service: \$ \_\_\_\_\_ Full fee is payable on or before the day of service for evaluations. Individual Services are billed monthly.

\_\_\_\_\_  
Agreement: I accept financial responsibility for the fee and terms of the educational services provided by Central Coast Language and Learning Center

Print name of person financially responsible

Signature and Date \_\_\_\_\_



**787 Munras Ave, Suite A Monterey, CA 93940**

**Phone 831.645.7900 Fax 831.645.7906 [www.coastalllearning.org](http://www.coastalllearning.org)**

## **Emergency Contact Information**

### **Student's Legal Name**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Nickname if used \_\_\_\_\_

Birthdate \_\_\_\_\_

### **With whom does student live?**

Mr./Mrs./Ms. \_\_\_\_\_

Relationship to student \_\_\_\_\_

Mailing Address \_\_\_\_\_

\_\_\_\_\_

Physical Address \_\_\_\_\_

\_\_\_\_\_

Primary Email for Family \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Mother's Name** \_\_\_\_\_

**Guardian's Name** \_\_\_\_\_ **Guardian's Name** \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Place of Business \_\_\_\_\_ Place of Business \_\_\_\_\_

**Emergency/Disaster/Unavoidable Delay:** List name of person(s) authorized to release or take your child from this center in case of any emergency or disaster. This child will NOT be allowed to leave with any other person(s) without permission from parent/guardian.

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_

**If personnel are unable to reach you in the event of a serious accident or illness, do you consent to the school calling an emergency medical service?**

Yes \_\_\_ No \_\_\_ **If NO, list alternatives here.**

List medications taken regularly. \_\_\_\_\_

Other schools attended \_\_\_\_\_

Other school-aged children in the home

Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

**Parent/Guardian signatures required:**

We have read the Attendance Policy and Cancellation Policy. Our signatures below affirm our understanding of these policies and confirm the accuracy of all information submitted hereby.

Mother (Guardian) \_\_\_\_\_ Date \_\_\_\_\_

Father (Guardian) \_\_\_\_\_ Date \_\_\_\_\_



## **Cancellation Policy**

We understand that sometimes you need to cancel or reschedule your appointments and there are emergencies. We also want to emphasize how important it is to attend each session on time and without too many cancellations or changes. If you are unable to keep your appointment, please notify us as soon as possible. Answering machine is on 24 hours a day. Because we do not double-book appointments, when you break your appointment, we are not able to fill the empty spot (Unless, at least 24 hour notice is given). As time and space is limited someone else may not be able to be seen by us.

### Fees for missed appointments:

For individual sessions (speech therapy, educational therapy, occupational therapy, etc.), there is a full visit fee for missed appointments without a 24 hour notice. 48 Hour advance cancellation is preferred and 24 is required. For group programs (Baby University, Avalon Preschool, summer programs), the full monthly rate for services is charged regardless of attendance.



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## Authorization for Release of Records and Information

Client's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby authorize "Central Coast Language and Learning Center" to exchange and/or discuss all language, learning, and/or psychoeducational evaluation and assessment records

With:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This consent is valid from \_\_\_\_\_ to \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Parent/Guardian



**Authorization for Release of Video/Photographs and Student Art Work**  
*For the specific use in advertisement, and professional and community outreach*

Client's Name: \_\_\_\_\_

I hereby authorize "Central Coast Language and Learning Center" to use photographs of my child and his or her artwork.

No, please only use my child's image for the following:

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Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Parent/Guardian



## Voluntary Excursion/ Field Trip Waiver And Medical Authorization

Program: \_\_\_\_\_

Dear Parent/Guardian:

This is a blanket waiver for all field trips and off-site activities which may occur during regular program hours.

\_\_\_\_\_ has my permission to participate in any authorized voluntary activities for the \_\_\_\_\_ program session.

I am aware that during any field trip or excursion certain dangers may occur including, but not limited to, the hazards or accidents or illness in places without medical facilities, hazards created by the force of nature and hazards of travel by air, train, bus, automobile, and other means, including walking.

In the event of an injury, I do hereby consent that whatever x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed by or under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

I understand that I may assume all of the above mentioned risks, will hold CCLLC and all of its employees harmless of any and all liability claims whatsoever, which may arise out of or in connection with a trip or participation in any activities arranged for the participant by CCLLC. The terms thereof shall serve as a release and assumption of risk for my heirs, executor and administrators and for all members of my family.

I fully understand that participants are to abide by all of the rules and regulations governing conduct during the trip. Any violation of these rules and regulations may result in that individual being sent home at his/her and/or parents expense.

_____ Signature of Parent/Guardian	_____ Date	_____ Phone
_____ Student's Name	_____ Date of Birth	
_____ Family Medical Insurance Carrier	_____ Address	_____ Policy Number



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## **Health Policy / Attendance Policy**

Every school year, teachers are concerned when children who are not well attend school. Health and education laws in California require that children be excluded from school when they have any communicable illness. While it is not always possible to determine whether a child might become ill during the school day, it is essential to take great care so that children do not come to school with possible infectious illnesses. If a child does not appear completely well, s/he should remain at home. A child with a contagious illness puts not only classmates “at risk” but also participating mothers who may be pregnant and infants in backpacks. It is the parents’ responsibility to consider the health and well being of all children, students, and staff when sending their child to school.

Listed below are guidelines to help determine whether a child is well enough to attend school:

### **Fresh Colds**

The period during which cold viruses are contagious ranges from one to three days. Since it is impossible to determine which virus caused a particular cold, children should remain at home for *at least three days* from the onset of symptoms.

### **Conjunctivitis (“pink eye”)**

There are two forms of conjunctivitis commonly seen in preschoolers. One is bacterial and requires antibiotic treatment. The other, highly contagious form is viral. Parents and children with conjunctivitis should consult a physician before allowing them to return to school.

### **Strep Throat**

Strep throat is a bacterial infection requiring antibiotic treatment. Twenty-four hours after treatment has begun, strep throat is no longer considered communicable. However, children do not often feel well enough to return to school after the 24-hour period. They should not come to school until their energy level is back to normal.

## **Fever**

Following any fever, a child should remain at home until s/he has been without fever for at least 24 hours. Note that during the early morning hours, a child's temperature will often register at normal, whereas later in the day it may rise again. This is one reason why a child needs a period of at least 24 hours without an elevated temperature before returning to school.

## **Vomiting and Diarrhea**

A child needs at least 24 hours without these symptoms before the child can attend school.



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## **HIPPA Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information, Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic, that may identify you and that relates to your past, present or future physical and mental health or condition and related health services.

### Uses and Disclosures of Protected Health Information

Your Protected Health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for providing health care services to you, to pay your health care bills, to support the operation of the providers practice, and any other use required by law.

### Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

### Payment

Your protected health information will be used, as needed, to obtain payment for your health care services.

## Healthcare Operations

We may use or disclose, as-needed, your protected health information in order to support the business activities of the practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to students that see clients at our office. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health oversight: Abuse or Neglected: Food and Drug Administration requirements: Legal Proceedings: Law enforcement: Coroners, Funeral Directors, and Organ Donation: Research Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time , in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosures indicated in the authorization.

## Your Rights

Following is a statement of your rights with respect to your protected health information.

### You have the right to inspect and copy your protected health information

Under Federal Law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

### You have the right to request a restriction of your protected health information

This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your provider amend your protected health information  
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

#### Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

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

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_\_\_