**Speech Sounds 2024 Pediatric Summer Camp**

Led by two of our speech language pathologists, Speech Sound Camp is an intensive therapy group that focuses on improving speech intelligibility and production of various speech sounds in the context of peer and group interactions. Improving speech skills is facilitated through massed practice in shared book reading and facilitated play. Children will practice speech skills to navigate group activities, improve their intelligibility to unfamiliar listeners, and repair communication breakdowns.

Dates: Monday through Friday (5 times per week) June 17-June 28

Time: 9-11:30am

**Criteria:**

* Age Range 4-8 years

**A physician referral/prescription is required to participate in the camp. Participants must have an insurance policy that will cover group therapy.**

Please contact your insurance company to inquire if your child’s benefits cover “group therapy” code: 92507 and/or 92508. For more information on insurances we currently accept, please see our website: <https://www.sralab.org/contact/insurance>. Here you will also find the numbers to contact for patient financial services and our managed care teams. **Parents are responsible for knowing insurance limitations with therapy coverage.**

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| I have checked my insurance and it does cover group therapy code 92507 and/or 92508 | ☐ | ☐ |
| I **HAVE** used other therapy benefits elsewhere | ☐ | ☐ |
| If checked yes to the previous question, please use this line to enter how many visits have been used elsewhere. Family is responsible for knowing their max visits. | Visit Number: |  |
| I understand that I am liable for any additional charges that my insurance does not cover | ☐ | ☐ |
| I **HAVE** a visit limit | ☐ | ☐ |
| If checked yes to the previous question, please use this line to enter how many visits are allowed. Family is responsible for knowing their max visits. | Number of visits: |  |
| Max amount of units allowed per day | Unit number allowed: |  |

Patient Full Name Patient DOB

Printed Parent Name Parent/Legal Guardian Signature

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**Please print and complete all entries**

Patient Name: Patient Birth Date:

Address: Caregiver Name:

Home Phone: Cell Phone:

Caregiver Email:

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Primary Doctor/Pediatrician:

Ordering Physician (for camp):

Emergency Contact: Relationship:

Phone Number:

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**Insurance Information Insured/Responsible Party**:

Relation to Patient:

Birth Date:

Address (if different from patient):

**Primary Insurance:**

Address:

Phone Number:

Group Number: ID Number:

**Secondary Insurance:**

Address:

Phone Number:

Group Number: ID Number:

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