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Speech-Language Development, SLP P.C.

Lyudmila Kimyagarova
Director

MACCC/TSHH P.R.O.M.P.T. trained-Level II
Speech-Language Pathologist
NYC License # 014994

FALL-WINTER-SPRING THERAPY SCHEDULE

(Please complete separate sheet for each therapy schedule)

Patient Name:_____DOB:_____

Age:_____

Address:_____

Phone Number: Home:_____Work:_____

Cell:_____

Please Circle:

Sessions per week: 1 2 3 4 5

Individual Group Both

Length of session: 1 hour 45 minutes 30 minutes

Monday	Tuesday	Wednesday	Thursday
8:00am			
8:00pm			

Please indicate a range of available and preferred times above by writing directly under the day, e.g., Wed. (9:00am through 12:00pm), Thurs. (5:00pm through 7:00pm)

**Please indicate alternate days/times:_____

I would prefer a more flexible schedule (different time each week). Please elaborate:_____

_____

Type of Problem:_____

Do you have a 60-day limit with your insurance?_____

Date you are able to begin:_____

Thank you,

Milla Kimyagarova, MACCC
Speech-Language Pathology