Language Preference Form

Primary language spoken at home:

- ☐ English
- ☐ Spanish
- ☐ Haitian Creole
- ☐ Portuguese
- ☐ French
- ☐ American Sign Language (ASL)
- ☐ Other: _____

Language the patient prefers:

- ☐ English
- ☐ Spanish
- ☐ Haitian Creole
- ☐ Portuguese
- ☐ French
- ☐ American Sign Language (ASL)
- ☐ Other: _____

Language parent/legal representative prefers:

- ☐ English
- ☐ Spanish
- ☐ Haitian Creole
- ☐ Portuguese
- ☐ French
- ☐ American Sign Language (ASL)
- ☐ Other: _____

Would you like an interpreter for appointments or meetings?

- ☐ Yes
- ☐ No interpreter requested at this time

If yes, preferred interpreter language/dialect: _____

Written materials and reports are typically provided in English.

Additional information that may help us support your family's language needs:

_____

☐ I understand that services and accommodations may vary based on availability and clinical appropriateness.

We will make reasonable efforts to accommodate language needs with advance notice. In some cases, referral to a bilingual evaluator may be recommended to ensure assessment accuracy.

Electronic Signatures and Records

By signing this form electronically, I agree that my electronic signature and any related electronic records shall have the same legal validity and enforceability as a handwritten signature and paper documents. I acknowledge the use of electronic records for this agreement.

Parent or Legal Representative Acknowledgment of Receipt and Review (for Minors or Individuals Lacking Legal Capacity)

I acknowledge that I have received, read, and understood the Language and Communication Preferences of Pediatric Neuropsychology Associates PLLC. I understand that this document is provided for informational purposes and does not require my consent for services.

By signing below, I confirm that I am the parent or legal representative of the patient named below and that I have the legal authority to receive and acknowledge this information on the patient's behalf.

I understand that I am not required to sign this acknowledgment. If I choose not to sign, the practice will document that the document was provided to me.

Printed Name of Patient: _____

Printed Name of Parent/Legal Representative: _____

Signature of Parent/Legal Representative: _____

Relationship to Patient: _____

Date: _____

A copy of this signed form will be retained in the patient's health records.

For Office Use Only

Date Received: _____

Received By: _____

Staff Role: _____

Filing Method: ☐ Paper File ☐ Digital File ☐ Both

Notes: _____