The Speech and Learning Center, L.L.P.
New Patient Information

Patient Name: _____
Date of Birth: _____ Age: _____ Sex: M or F

Who does the patient live with? _____
Address: _____
City: _____ State: _____ Zip Code: _____

Parent #1 Name: _____ D.O.B.: _____
Address: _____
Phone #1: _____ Phone #2: _____
Email address: _____
Employer: _____ Work Phone: _____
Driver's License #: _____ State: _____

Parent #2 Name: _____ D.O.B.: _____
Address: _____
Phone #1: _____ Phone #2: _____
Email address: _____
Employer: _____ Work Phone: _____
Driver's License #: _____ State: _____
Adult Patient:
Email address: _____
Employer: _____ Work Phone: _____
Driver's License #: _____ State: _____

How did you hear about our clinic? (Please circle all that apply)

Friend Physician Sienna Newsletter Insurance Social Media Sign
Internet Search Employee School/ECI Other: _____

Please list specific friend or physician so we can thank them for the referral: _____

Primary Physician: _____Physician Phone: _____
Primary Physician FAX: _____

Emergency Contact Name: _____ Phone: _____
Emergency Contact Address: _____

Insured's Name: _____ Phone: _____ DOB: _____
Insured's address: _____ SS#: _____
Insurance Provider: _____ Phone #: _____
Insurance ID #: _____ Group #: _____

The Speech and Learning Center, L.L.P.
Emergency Medical Release

Dear Patient:

In the event that medical attention is required while on the premises of The Speech and Learning Center, L.L.P., it will be necessary to have authorization for medical care and an emergency contact on file. Please fill out the following information in its entirety.

Patient Name: _____

Emergency Contact: _____

Primary Care Physician: _____ Physician Phone #: _____

Known Allergies: _____

Current Medications: _____

Medication/Allergies: _____

Other Health/Medical Information: _____

Emergency Contact Phone Numbers (Provide 2 numbers):
_____; _____

Caretaker Phone Numbers if different from above: _____

Alternate Name/Number: _____

I give my permission for The Speech and Learning Center, L.L.P., to provide emergency medical services for minor injuries received while on the premises if a caregiver is not onsite. In the event that an emergency is life threatening, I give my permission for The Speech and Learning Center, L.L.P., to contact emergency medical personnel. I understand that I am fully responsible for any financial costs that are incurred.

Signature of Patient: _____ Date: _____

The Speech and Learning Center Witness: _____ Date: _____

Will your child ever be brought to therapy by someone other than parents/guardians? **Yes / No**

If **yes**, please list First and Last Name of each individual and best phone number:
_____
_____

The Speech and Learning Center, L.L.P.
Release/Request of Information

1. Permission to fax evaluation report to physician

I _____ (responsible party's name) give my permission to The Speech and Learning Center to release _____ (patient's name) evaluation reports and patient records to _____ (physician's name(s)). By signing below, I acknowledge the above statement will remain valid until I provide a written request to discontinue permission.

Responsible party's signature: _____ Date: _____

2. Permission to correspond with caregiver via email

I _____ (responsible party's name) give my permission to The Speech and Learning Center to send/receive information regarding _____ (patient's name) therapy via email to patient or patient's caregiver. By signing below, I acknowledge the above statement will remain valid until I provide a written request to discontinue permission.

Responsible party's signature: _____ Date: _____

3. Permission to correspond with other professionals

I _____ (responsible party's name) give my permission to The Speech and Learning Center to release/receive information regarding _____ (patient's name) to professionals involved in this patient's care. Such professionals may include physicians, teachers, speech pathologists, occupational therapists, physical therapists, reading specialists, private tutors, behavior therapists, etc. Correspondence may occur via email, telephone, mail, virtual meetings, or fax. By signing below, I acknowledge the above statement will remain valid until I provide a written request to discontinue permission.

Responsible party's signature: _____ Date: _____

4. Permission to correspond with care providers (e.g. grandparents, nannies, RBT, etc...)

I _____ (responsible party's name) give my permission to The Speech and Learning Center to release/receive information regarding _____ (patient's name) to my child's _____ (name of relative). By signing below, I acknowledge the above statement will remain valid until I provide a written request to discontinue permission.

Responsible party's signature: _____ Date: _____

5. Permission for direct/indirect professionals to observe

I _____ (responsible party's name) understand that The Speech and Learning Center provides teaching opportunities for students and interns and give permission for myself/my child to be observed for teaching purposes. I also understand that at times, professionals outside of The Speech and Learning Center (e.g. behavior therapists) may be on premises observing a patient other than my own child and may indirectly observe myself/my child in the clinic. By signing below, I acknowledge the above statement will remain valid until I provide a written request to discontinue permission.

Responsible party's signature: _____ Date: _____

6. Permission for photo and video on social media and website

I _____ (responsible party's name) give permission for The Speech and Learning Center to take photos/video of my child and post on social media and/or their website for educational and advertisement purposes. I understand that to revoke this approval, I must present this request in writing.

Responsible party's signature: _____ Date: _____

The Speech and Learning Center, L.L.P.

Office Policy

We appreciate the confidence you have expressed in selecting us as your speech therapy and occupational therapy provider. If you have any questions about our services, fees, or other aspects of your care, please feel free to discuss them with us.

Fee Agreement

____ Payments for assessment and therapy are due prior to rendering of services unless prior arrangements have been made with your insurance carrier. Our office accepts checks and all major Credit/Debit cards. Payment in full for services rendered is required at the time of service for:

1. Patients without insurance
2. Patients who do not provide us with contracted insurance information
3. Patients whose insurance plans do not cover speech and occupational therapy
4. Patients who are required to have prior referral/authorization from their insurance carrier or Primary Care Physician, who have not obtained such authorization.

____ **All amounts owed by patients** under contracted insurance plans (copays, coinsurance, deductibles, and non-covered services) **are payable at the time of service**. Any service that is rendered by this office which is not a covered benefit under your insurance policy is your responsibility to pay. In the event that your payment is not made in a timely manner, information regarding your delinquent account will be forwarded to our attorney or collection agency. Should this become necessary, the customer agrees to pay reasonable attorney and/or court fees and any other costs incurred by The Speech and Learning Center, L.L.P.

____ **All patients are required to have a credit card on file.** Cards will be charged the day of the visit for the total patient responsibility. This includes private pay, copays, co-insurance, deductibles, no show/late cancel fees.

____ Our staff will assist you in dealing with your insurance company by verifying your benefits using the member services phone number given on your insurance card; however, this verification is not a guarantee of payment, and it is your responsibility to know and understand your own insurance benefits, coverage, pre-existing condition clauses, and referral/authorization requirements. Please remember that your insurance is a contract between you and your insurance company and/or employer. We recommend that any questions regarding the amount of insurance coverage be discussed directly with your insurance company and/or employer. It is your responsibility to notify us of changes in insurance. If changes in insurance result in non-payment, the patient is responsible for payment.

____ **It is the patient's responsibility to notify our office of a change in insurance plans.** Any balance accumulated that we are unable to collect due to not being notified of an insurance plan change is the responsibility of the patient.

____ Additionally, if payment from your insurance company is not received within 45 days of the billing date, the amount owed will be your responsibility. If, in the future, insurance payment is received you will receive a refund or credit. Patients will be given a 60-day grace period to pay their responsibility. Any amount not paid by then will be charged to the credit card on file.

Possible Additional Fees

____ The Speech and Learning Center charges a $35.00 returned check fee on each check not covered by your bank.

____ Caregiver will be charged $10 if not present by end of session to pick up child, with an additional $2 minute after the first 10 minutes.

____ Additional charges may occur for parent education meetings, meetings with other professionals, etc. This is based upon individual insurance plans. Please be sure to speak with our billing specialist if you want to schedule a meeting with your therapist so you are aware of your financial responsibility in advance.

____ Charge for first 10 pages of medical records is $25. Each additional page is 2. Please allow 10 business days when requesting medical records.

Appointments & Scheduling

____ Due to the rising number of patients who do not cancel their appointments when circumstances prohibit them from appearing at our office, we have instituted a "no show/late cancellation fee." The Speech and Learning Center, L.L.P., requires a 24-hour cancellation notice. **Therapy appointments broken without 24-hour notice will be charged $75.00. This fee will be automatically charged to the credit card on file the day of the late cancel/no show.** If the missed appointment is made up within 2 weeks and the credit card has been charged, a refund will be provided. This fee will not be charged if a telephone cancellation due to illness or extenuating circumstances is received in our office **prior** to your appointment time. This fee is **not** billable to your insurance company. Patients with outstanding no show/late cancel fees cannot be seen until this is paid in full. This policy applies to private pay and patients with all insurance plans.

____ Frequent cancelations due to illness may result in request for doctor's note or removal from schedule. This is required due to the strict attendance policies insurance requires to continue payment of services and to assist with the patient's progress.

____ Three consecutive no shows/late cancels result in automatic removal from the schedule. Frequent cancelations or now shows for any reason may also result in removal from schedule.

____ I understand I may be placed on the "Flex Schedule" for frequent no shows and cancellations for any reason. This means that you will no longer have standing appointments and **moving forward you will need to call our office each week to check for appointment availability.** Patients on the flex schedule are expected to attend sessions regularly in order for progress to occur and for insurance to continue coverage.

____ Removal from permanent schedule to "Flex Schedule" is determined at the discretion of your therapist.

____ I understand that I must arrive on time for every appointment as **being more than 10 minutes late results in my appointment being rescheduled.** Frequent late arrivals may result in removal from schedule. Consistent, timely attendance is necessary to progress in therapy goals. Lack of consistent attendance will result in discharge from therapy, as progress cannot be made without consistent attendance.

____ Please do not email or text any staff member as a form of cancelling appointments as we are not always able to check emails/texts. **Any cancelations must be made with a front office staff**, **by phone call,** or **messaged through Klara**. **Klara is our preferred method for cancellations.**

____ **ABA Observation Policy:** All observations MUST BE pre-scheduled and approved by the treating therapist and administration. A one-week advance request is required unless approved otherwise for extenuating circumstances. BCBA's and RBT's are initially welcome to observe 1-2 sessions. After 1-2 sessions, observations are welcomed quarterly. Exceptions will be made when the treating therapist requests ABA presence more frequently to assist with patient's progress. Monthly virtual/phone meetings with the BCBA, RBT, parent, and treating therapist(s) are available up to once a month. Before scheduling, please communicate with our billing specialist to determine patient responsibility, as this service is not always covered by insurance.

____ **Please do not leave your children unattended in the lobby.** Our office cannot be responsible for children left unattended. If the caregiver does not return 5 minutes before end of session, they forego speaking with the therapist.

____ The Speech and Learning Center closes the following holidays each year: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, Christmas Eve, Christmas Day, and New Year's Eve. Regular hours are maintained all other holidays unless otherwise notified.

____ Patients are encouraged to reschedule any missed appointments due to illness, holiday office closures, etc. in order to expedite the patient's progress and should speak with the front desk to reschedule.

Health & Safety

____ I agree to follow all health and safety precautions set in place by The Speech and Learning Center. These are important measures to protect both our staff and patients. This includes that patients must be fever free without medications for 24 hours following an illness. This is important in order to help keep our patients and staff healthy.

I authorize The Speech and Learning Center, L.L.P. to provide appropriate evaluation and treatment as needed. Additionally, I authorize the release of any necessary information acquired in the course of the evaluation or treatment process to my referring physician, health plan/ insurance representative, or attorney. I have read and understand the above information as well as the insurance benefits verified from my insurance carrier, if applicable. I understand that I am responsible for all charges whether or not reimbursed by my insurance company.

_____	_____	_____
Signature	Print Name	Date

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF

THE SPEECH AND LEARNING CENTER, L.L.P

NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge receiving The Speech and LearningCenter, L.L.P. Notice of Privacy Practices ("Notice"). The Notice explains how The Speech and LearningCenter, L.L.P. may use or disclose your protected health information for treatment, payment, and health care operations purposes. "Protected Health Information" means your personal health information found in your medical and billing records.

The Speech and LearningCenter, L.L.P. reserves the right to change the Notice from time to time. A copy of the current Notice or summary of the Notice will be posted. The effective date of the Notice will appear on the first page of the Notice or summary. The Speech and LearningCenter, L.L.P. will have available for you, at your request, a copy the current Notice in effect.

Your signature below only acknowledges that you have RECEIVED the Notice.

If you have any questions about the Notice, please contact The Speech and LearningCenter, L.L.P.

Name of Patient (Printed): _____

Date of Birth: _____

Name of Patient's Representative (Printed): _____

Relationship of Patient's Representative to Patient: _____

Signature of Patient or Patient's Representative: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this facility. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this facility is required by law to maintain the privacy of that information.

This facility is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer(s) at this facility.

Who Will Follow This Notice
Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this facility who may need access to your information must abide by this Notice.

Changes to This Notice
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date on the posted copy.

THE SPEECH AND LEARNING CENTER, L.L.P.
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.

EFFECTIVE DATE: January 1, 2005

How We May Use and Disclose Medical Information about You
The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment: We may use medical information about you to provide you with medical treatment or services. Example: If your assigned Speech Pathologist is on vacation, he or she may disclose to another therapist about you or your child.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you or an insurance company. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use or disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law

We may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization
Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke that authorization, we will therefore no longer use or disclose medical information about for the reasons covered by your written authorization. We are unable to take back any disclosures we have

already made with your authorization, and we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING

Disclosures and Changes to Your Medical Information

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. To request restrictions, you must submit your request in writing to the Privacy Officer(s) at the facility. In your request, you must tell us what information you want to limit.

Right to an Accounting of Non-Standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officers at this facility. Your request must state the time period for which you want to receive a list of disclosures that is no longer that six years, and may not include dates before January 1, 2005. Your request should include in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer(s) at this facility. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

YOUR ACCESS TO MEDICAL INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records. Information complied for use in a civil, criminal, or administrative action or processing, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer(s) at this facility. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to a Paper Copy of This Notice: You have the right to a paper copy of our current Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are

still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer(s) at this facility.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you make your request to the Privacy Officer(s) at this facility. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on this facility.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer(s) at this facility or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.