PLEASE KEEP THIS COPY FOR YOUR RECORDS—DO NOT RETURN!

Speech Therapy Plus, Inc.
Notice of Privacy Practices

This Notice Describes How Medical Information About Your Child May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

This Notice is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This notice describes how we may use and disclose your child's protected health information (PHI) to carry out treatment, payment, and healthcare operations and for other purposes that are permitted or required by law. PHI includes any of your child's written or oral health information including demographic data that can be used to identify your child. This is PHI that is created or received by Speech Therapy Plus, Inc. and/or its agent.

Understanding Your Child's Health Information

Each time your child receives health related services a record is made of the treatment. Typically, this record contains the child's diagnosis and treatment notes. This information, often referred to as a health, treatment or medical record, serves as a:

- Basis for planning your child's care
- Means of communicating among the health professionals (physician) who contribute to your child care
- Legal document describing the care your child received
- Means by which you or a third-party payer (Medicaid OR other Health Insurance) can verify that services billed were actually provided

Your Child's Health Information Rights

Although your child's health record is the physical property of the facility, in this case, Speech Therapy Providers, Inc., the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your child's information as provided by 45 CFR 164.522
- Receive confidential communications of protected health information as provided by 45 CRF 164.522
- Inspect and copy your child's health record as provided for in 45 CFR 164.522
- Request to amend your child's health record as provided in 45 CRF 164.522
- Obtain an accounting of disclosures of your child's health information as provided in 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Obtain a paper copy of the notice from us upon request

The right to make a request does not guarantee it will be granted, the request may be denied based on certain situations; including, emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, for example. All requests must be made in writing and mailed OR emailed to:

Speech Therapy Plus, Inc.
105 FLORIDA AVE UNIT 2
CAROLINA BEACH, NC 28428
speechtherapyplus@tritxsoapnotes.com
FAX: 877-335-6220

Our Responsibilities

- Maintain the privacy of your child's protected health information (PHI)
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction

We will not use or disclose your child's health information without your authorization, except as described in this notice:

We will use your child's health information for treatment.

For example, information obtained by our health related services provider, speech language pathologist or occupational therapist, will be recorded in your child's record and used to determine the best plan of care for your child.

We will use your child's health information for payment.

We may use and give your child's health information to electronically bill Medicaid and collect payment for treatment services provided to your child by us or a contracted agent. Speech Therapy Plus, Inc is approved participating group provider of Medicaid. Medicaid only approved us as providers after making sure in writing that we as providers will safeguard your information in the same way Medicaid does.

PLEASE KEEP THIS COPY FOR YOUR RECORDS—DO NOT RETURN!

PLEASE SIGN AND RETURN AS SOON AS POSSIBLE!

SPEECH THERAPY PLUS, INC.

"FOCUSED ON THE CLIENT'S INDIVIDUAL NEEDS"

speechtherapyplus@tritxsoapnotes.com

Office: 252-633-6770/ Fax: 877-335-6220

CONSENT AND AUTHORIZATION TO TREAT AND EXCHANGE INFORMATION

Child's Name_____ DOB_____ Medicaid#_____

Other Insurance Name_____ Insurance # _____

Parent/Guardian's Name _____ Phone# _____

Address _____ County _____

As the parent/legal guardian of the above named patient, I give ***SPEECH THERAPY PLUS, INC*** permission to do the following in reference to the above named child:

● Perform a formal **speech/occupational** evaluation ● Provide **speech/occupational therapy** treatment as needed ● Bill PRIMARY insurance company listed above for payment electronically for all services to be paid directly to ***SPEECH THERAPY PLUS, INC.*** ● Provide copies of all EOBs from health insurance company to Speech Therapy Plus, Inc. to ensure accurate billing and payments.	● Release any information needed to Medicaid-Raleigh/ insurance company listed above in order to receive payment for services. ● Release ***and/or*** exchange ***any*** relevant information with the agencies/facilities listed below about the above named patient for assessment/treatment/payment purposes.

This request and authorization applies to health care information that may be needed as a part of the evaluation process, history and record review, insurance prior approvals, and continuity of care. AGENCIES MAY provide a copy of the following information:

PEDIATRICIAN'S OFFICE	LOCAL LEA FOR IEP	LOCAL CDSA FOR IFSP
☑ RECENT HEALTH ASSESSMENT ☑ HEARING SCREENING INFORMATION	☑ MOST RECENT DEC 4 ☑ DEC 3 ELIGIBILITY INFORMATION ☑ SPEECH AND OT EVALUATION REPORTS ☑ PROGRESS NOTES ☑ PLAN OF CARE	☑ EVALUATION REPORTS ☑ IFSP ☑ PROGRESS NOTES ☑ PLANS OF CARE

Agencies/Facilities *(Please add/delete any agency you do/do not want to have access to the child's health information) YOU MAY MARK THROUGH AND INITIAL ANY THAT YOU WOULD LIKE EXCLUDED OR WRITE IN THE NAMES OF OTHER INDIVIDUALS YOU WOULD LIKE INCLUDED.*

AGENCIES/FACILITIES TO RELEASE AND/OR EXCHANGE INFORMATION WITH:

Other agencies/facilities to release and/or exchange information with as appropriate for patient:

X Health Insurance Company **X** Speech Therapy Plus, Inc. **X** LOCAL LEA (PUBLIC SCHOOL) **X** LOCAL CDSA

X Head Start in County of Residence **X** LOCAL HEALTH DEPARTMENT **X** PEDIATRICIAN - MY PEDIATRICIAN IS AT THE FOLLOWING OFFICE:

_____

OTHERS TO INCLUDE: _____

OTHERS TO EXCLUDE: PLEASE LIST ANY AGENCY ABOVE YOU do not WISH TO ALLOW US TO EXCHANGE HEALTH INFORMATION WITH

_____

By providing my signature below, I understand and agree with all of the above and understand that the consent given is completely voluntary and can be revoked at any time, except for any action that has been taken prior to the date the consent is revoked. I UNDERSTAND THAT THIS CONSENT WILL EXPIRE WHEN MY CHILD IS DISCHARGED BY SPEECH THERAPY PLUS, INC OR UPON WRITTEN REQUEST TO REVOKE THIS CONSENT. I also understand that my signature acknowledges that I have been provided a copy of Speech Therapy Plus, Inc. Notice of Privacy Practices and that the notice is the result of federal regulation cited under the Health Insurance Portability and Accountability Act (HIPPA), effective 4-14-03, stating all providers of health related services are required to provide individuals receiving treatment and having services electronically billed for treatment with a copy of the Notice of Privacy Practices regarding protected health information.

Parent/Legal Guardian's signature:_____

Date Consent is signed: _____

PLEASE SIGN AND RETURN AS SOON AS POSSIBLE!

PLEASE SIGN AND RETURN AS SOON AS POSSIBLE!

SPEECH THERAPY PLUS, INC.

"FOCUSED ON THE CLIENT'S INDIVIDUAL NEEDS"

speechtherapyplus@tritxsoapnotes.com

Office: 252-633-6770/ Fax: 877-335-6220

PERMISSION FOR CHILD TO RECEIVE EDIBLE TREATS

_____ YES, I give permission my child _____ to receive edibles/treats before, during, and/or following therapy/evaluation sessions.

My child is **allergic to and/or is not allowed to eat** any of the following foods:_____

_____ NO, I DO NOT give permission for employees of Speech Therapy Plus, Inc. to give my child (name listed above) treats following therapy/evaluation sessions.

Parent/Legal Guardian's signature:_____

Date Consent is signed: _____

SPEECH THERAPY PLUS, INC./ SOCIAL/DEVELOPMENT HISTORY

CHILD'S NAME_____ DATE OF BIRTH _____

PARENT/CAREGIVER COMPLETING FORM _____ DATE_____

HAS YOUR CHILD EVER RECEIVED THERAPY BEFORE? _____YES OR ____NO

IF YES --WHAT TYPE? ___SPEECH___OT____PT WHERE? _____

DOES YOUR CHILD **HAVE OR EVER** HAD AN IEP OR IFSP? ____YES OR ____NO

THINKING ABOUT YOUR PREGNANCY AND THE BIRTH OF THIS CHILD PLEASE CHECK ANY THAT APPLY?

❑	NORMAL PREGNANCY	❑	HOSPITALIZED DURING PREGNANCY	❑	MOTHER WAS UNDER CARE OF A DOCTOR FOR PREGNANCY
❑	BABY WAS PREMATURE	❑	BABY WAS FULL-TERM	❑	MOTHER CONSUMED ALCOHOL

PLEASE LIST ANY COMPLICATIONS AT BIRTH:

BABY'S CONDITION AT BIRTH:

MEETING DEVELOPMENTAL MILESTONES PLEASE CHECK THE APPROPRIATE BOX:

MILESTONE	WITHIN NORMAL LIMITS	LATER THAN EXPECTED
SIT ALONE	❑	❑
STAND ALONE	❑	❑
CRAWL ALONE	❑	❑
WALK ALONE	❑	❑
SPEAK FIRST WORDS	❑	❑
SPEAK FIRST SENTENCES	❑	❑

DOES YOUR CHILD HAVE A HISTORY OF CHRONIC EAR INFECTIONS OR TUBES PLEASE DESCRIBE:

DOES YOUR CHILD HAVE ANY HEALTH PROBLEMS?

DOES YOUR CHILD TAKE ANY MEDICATION ON A REGULAR BASIS? IF SO, PLEASE LIST.

PLEASE DESCRIBE WHAT YOUR CHILD CAN DO WELL:

WHAT IS YOUR PRIMARY CONCERN FOR YOUR CHILD:

IS THERE ANY OTHER INFORMATION THAT YOU THINK WOULD HELP US UNDERSTAND YOUR CHILD BETTER?

HAS YOUR CHILD HAD ANY OF THE FOLLOWING PROBLEMS OR IS THERE FAMILY HISTORY?

TYPE OF PROBLEM	YES OR NO	PLEASE DESCRIBE
HEALTH OR MEDICAL CONDITION THAT REQUIRED HOSPITALIZATION	❑ YES ❑ NO	
SURGERIES	❑ YES ❑ NO	
UNUSUAL ILLNESS,ACCIDENTS, OR HIGH FEVERS	❑ YES ❑ NO	
ALLERGIES	❑ YES ❑ NO	
POOR EATING HABITS	❑ YES ❑ NO	
POOR SLEEPING HABITS	❑ YES ❑ NO	
BEDWETTING	❑ YES ❑ NO	
CRYING SPELLS	❑ YES ❑ NO	
TEMPER TANTRUMS	❑ YES ❑ NO	
FAILURE AT SCHOOL	❑ YES ❑ NO	
HEARING /VISION PROBLEMS	❑ YES ❑ NO	
ADHD/ADD	❑ YES ❑ NO	
SOCIAL OR BEHAVIOR PROBLEMS	❑ YES ❑ NO	
LEARNING OR UNDERSTANDING	❑ YES ❑ NO	

BELOW PLEASE RATE YOUR CHILD COMPARED TO OTHER CHILDREN HIS/HER AGE:

	NOT AS WELL AS OTHER CHILDREN	THE SAME AS OTHER CHILDREN	BETTER THAN OTHER CHILDREN
ABILITY TO FOLLOW DIRECTIONS	❑	❑	❑
GETS ALONG WITH OTHER CHILDREN	❑	❑	❑
GETS ALONG WITH ADULTS	❑	❑	❑
LEVEL OF ACTIVIITY	❑	❑	❑
ATTENTIVENESS	❑	❑	❑
SPEECH	❑	❑	❑
COORDINATION (GROSS MOTOR)	❑	❑	❑
FINE MOTOR SKILLS (HANDWRITING, ETC.)	❑	❑	❑
INTEREST IN BOOKS	❑	❑	❑
SELF HELP SKILLS	❑	❑	❑

ONLY COMPLETE THE FOLLOWING FORM IF YOUR CHILD IS 5 YEARS OLD OR YOUNGER

PLEASE ANSWER YES OR NO FOR THESE ITEMS. THESE QUESTIONS RELATE TO WHAT YOUR CHILD CAN OR CANNOT UNDERSTAND WHEN SOMEONE IS TALKING TO HIM OR HER (AUDITORY COMPREHENSION) AND HOW WELL THEY CAN TELL YOU WHAT THEY KNOW (EXPRESSIVE COMMUNICATION):

MY CHILD IS ABLE TO:	YES	NO	NOT SURE	MY CHILD IS ABLE TO:	YES	NO	NOT SURE
Glances momentarily at a person who talks to him/her	YES	NO	?NOT SURE	Demonstrates appropriate use of objects in play	YES	NO	?NOT SURE
Enjoys caregiver's attention	YES	NO	?NOT SURE	Identifies photographs of familiar objects	YES	NO	?NOT SURE
Reacts to sounds other than voices in the environment	YES	NO	?NOT SURE	Understands inhibitory words like "wait" and "stop"	YES	NO	?NOT SURE
Looks intently at a speaker	YES	NO	?NOT SURE	Indicates body parts on self, caregiver, or teddy bear	YES	NO	?NOT SURE
Turns head to locate the source of a sound	YES	NO	?NOT SURE	Understands verbs in context	YES	NO	?NOT SURE
Actively searches to find a person who is talking	YES	NO	?NOT SURE	Identifies clothing items on self or caregiver	YES	NO	?NOT SURE
Discriminates one sound from another	YES	NO	?NOT SURE	Understands spatial concepts (in, off, out of)	YES	NO	?NOT SURE
Puts objects in the mouth	YES	NO	?NOT SURE	Recognizes actions in pictures	YES	NO	?NOT SURE
Shakes and bangs objects in play	YES	NO	?NOT SURE	Understands several pronouns (me, my, your)	YES	NO	?NOT SURE
Interrupts activity when you call his/her name	YES	NO	?NOT SURE	Understands use of objects	YES	NO	?NOT SURE
Anticipates what will happen next	YES	NO	?NOT SURE	Understand part/whole relationships	YES	NO	?NOT SURE
Actively searches for source of sound that is out of sight	YES	NO	?NOT SURE	Understands simple descriptive concepts (big, wet, little)	YES	NO	?NOT SURE
Looks at objects or people the caregiver calls attention to	YES	NO	?NOT SURE	Follows two-step directions without cues	YES	NO	?NOT SURE
Understands what "come with me" means	YES	NO	?NOT SURE	Understands quantity concepts (one, some, rest, all)	YES	NO	?NOT SURE
Responds to "no-no"	YES	NO	?NOT SURE	Understands the pronouns his and hers	YES	NO	?NOT SURE
Understands a specific word or phrase other than "no"	YES	NO	?NOT SURE	Understands negative sentences (which one is not?)	YES	NO	?NOT SURE
Uses more than one object/toy during play	YES	NO	?NOT SURE		YES	NO	?NOT SURE
Follows routine, familiar directions with cues	YES	NO	?NOT SURE				

"ONLY COMPLETE THE FOLLOWING FORM IF YOUR CHILD IS 5 YEARS OLD OR YOUNGER" CONTINUED

MY CHILD IS ABLE TO:							
Has a suck/swallow reflex	YES	NO	?NOT SURE	Uses five to ten words	YES	NO	?NOT SURE
Vocalizes soft, throaty sounds	YES	NO	?NOT SURE	Uses vocalizations and gestures to request toys or food	YES	NO	?NOT SURE
Responds to someone talking by smiling	YES	NO	?NOT SURE	Produces different types of consonant-vowel combinations	YES	NO	?NOT SURE
Varies pitch, length, and volume of cries	YES	NO	?NOT SURE	Babbles syllable strings W/ inflection like adult speech	YES	NO	?NOT SURE
Vocalizes pleasures and displeasure sounds	YES	NO	?NOT SURE	Names objects in photograph	YES	NO	?NOT SURE
Vocalizes when talked to, moving arms and legs w/ sound	YES	NO	?NOT SURE	Uses words more often than gestures to communicate	YES	NO	?NOT SURE
Protest by gesturing of vocalizing	YES	NO	?NOT SURE	Asks question	YES	NO	?NOT SURE
Vocalizes two different vowel sounds	YES	NO	?NOT SURE	Uses words for a variety of pragmatic functions	YES	NO	?NOT SURE
Vocalizes two different consonant sounds	YES	NO	?NOT SURE	Uses different word combinations	YES	NO	?NOT SURE
Combines sounds to form a syllable	YES	NO	?NOT SURE	Uses plural "s" to describe more than one	YES	NO	?NOT SURE
Seeks attention from others	YES	NO	?NOT SURE	Combines three or four words in spontaneous speech	YES	NO	?NOT SURE
Plays simple games	YES	NO	?NOT SURE	Answers what and where questions	YES	NO	?NOT SURE
Uses gestures to communicate (pointing, pushing, pulling)	YES	NO	?NOT SURE	Uses verb + ing to describe actions	YES	NO	?NOT SURE
Able to vocalize without arm and leg movements	YES	NO	?NOT SURE	Uses a variety of nouns, verbs, modifies, and pronouns	YES	NO	?NOT SURE
Participates in play routine w/ another person for 1-2 mins	YES	NO	?NOT SURE	Produces basic four- to five- word sentences	YES	NO	?NOT SURE
Babbles two syllables together (mama, dada)	YES	NO	?NOT SURE	Names a variety of pictured objects	YES	NO	?NOT SURE
Has a vocabulary of at least one word	YES	NO	?NOT SURE	Tells how and object is used	YES	NO	?NOT SURE
Initiates turn-taking game or social routine	YES	NO	?NOT SURE	Uses quantity concepts (some, more, all, the rest)	YES	NO	?NOT SURE
Extends a toy or points to an object to show others	YES	NO	?NOT SURE	Uses possessives (This is the "cat's" bowl)	YES	NO	?NOT SURE
Produces a variety of consonant sounds	YES	NO	?NOT SURE				?NOT SURE
Imitates words	YES	NO	?NOT SURE				