The Speech House, LLC

Laying the foundation for communication

CLIENT INFORMATION

Patient:_____DOB: _____**S**ponsor's SSN: _____

Last First Middle

Address_____

Street City ZIP

Cell Phone: _____ Text: Y or N Email: _____

Parent/Guardian Information (if applicable)

Name 1:_____DOB: _____

Last First Middle

Address_____

Street City ZIP

Cell Phone: _____ Text: Y or N Email: _____

Name 2:_____DOB: _____

Last First Middle

Address_____

Street City ZIP

Cell Phone: _____ Text: Y or N Email: _____

Physician

Primary Care Physician: _____ Phone:_____

Primary Dentist: _____ Phone: _____

Referring Physician: _____ Phone: _____

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Patient Name:_____ **Date of Birth:** _____

Insurance

Primary Insured**:**_____DOB: _____

Primary Insurance Carrier:_____Phone Number: _____

Billing/Claim Address:_____City:_____State: _____

ID #:_____Group #: _____

Secondary Insurance: _____

Policyholder Name:_____DOB:_____

Phone Number:_____ Billing/Claim Address:_____

City:_____State: _____ Zip:_____

Policy Group or #:_____Group #: _____

Assignment of Benefits (insurance patients only):

I_____, authorize the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims. I hereby authorize payment directly to The Speech House of the insurance benefits otherwise payable to me for all professional services.

Signature of Responsible Party:_____Date:_____

Payment Contract

Applicable to Self/Private Pay and Insurance Copays

Responsible Party: _____

Relationship Party : Self _____Parent_____Other (specify) _____

Preferred payment option:

_____I hereby acknowledge and agree to pay treatment fee balances at the time of service (cash or check).

_____I hereby authorize The Speech House, LLC, to use Autobooks weekly in order to keep my/my child's account balance current with the below listed credit card information.

_____I hereby acknowledge and agree to pay treatment fee balances monthly (cash, check, credit card (below listed).

_____I understand that I have the right to cancel my Autobooks with 10 day written notification provided to The Speech House, LLC..

Card Information

_____ Mastercard _____Visa _____Debit _____ AmEx

Card Holder Name: _____

I understand this information is kept private and confidential and is protect by HIPPA regulations under patient confidentiality.

Signature of Responsible Party or Patient:_____ Date:_____

Card Number:_____ Exp. Date:_____ CVV:_____

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POLICIES AND PROCEDURES

CANCELLATION POLICY

If you must cancel an appointment, please call/text the office at least 24 hours in advance. Except under emergency circumstances and acute illness, all appointments cancelled with less than 24 hours notice may be subject to a $25 service fee. There will be ONE "failure to cancel" courtesy provided. After three (3) no-shows, the patient will be put on probation. The three (3) no-shows may result in termination of service and notification to the referring physician. If you arrive late for your appointment, we will do our best to see you; however, the appointment may be shortened due to time constraints.

TERMINATION OF SERVICES

Due to the importance of continuity of care, regular attendance to appointments is necessary. If excessive appointments are missed and/or canceled, The Speech House reserves the right to discharge services. In the event that you do not keep your financial obligations to The Speech House and remain delinquent on your account for more than 30 days, services will be suspended until payment is received. Services may also be terminated if it is determined that continued participation will be a detriment to the child or their family.

The Speech Language Pathologist reserves the right and professional judgement to discontinue services.

CONFIDENTIALLITY

Your privacy is very important to us. I strongly recommend that you review the **Notice of Privacy Policy** for important details regarding policies for maintaining confidentiality. In particular, you should be aware that we will only contact you via means that you have specifically authorized in your new client paperwork. If you would like us to exchange information with persons other than yourself, an Authorization for Release of Information form must be completed.

HEALTH POLICY

Help and cooperation is required to maintain a healthy environment. A child must be temperature-free for 24 hours before returning to therapy. If your child has experienced vomiting and/or diarrhea, he/she should not return to therapy until 24 hours have passed since the last episode of the same.

Please do not bring sick or febrile family members to the clinic.

Children will not be seen if any of the following is present: Too ill or uncomfortable to function in the therapy setting, continual runny nose; thick or discolored nasal discharge; excessive sneezing or coughing and mucus-producing cough; an elevated temperature.

Strict CDC guidelines are followed for COVID-19.

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SIBLINGS

If you need to bring siblings to the clinic, please have them use their inside voices in the waiting room and be respectful of our space, so as not to disturb others in session or waiting in the shared space.

HEALTH INSURANCE

We participate with some insurance companies, but not all. If The Speech House is not contracted with your insurance, we will be happy to provide you with a superbill to assist you in seeking reimbursement for out-of-network provider services. Please also be advised that many health insurance plans have limited coverage for speech-language pathology services. We recommend that you contact your insurance company to discuss the limits of your coverage.

FEES

The person who completes the **Party Responsible for Payment** section is responsible for payment of all services rendered. Payment is due at the time services are rendered unless you have made other arrangements in advance. **Accounts more than 30 days overdue will be subject to a $20.00 late fee and 5% interest charge. Accounts more than 90 days overdue will be sent to collections**. For clients seeking insurance reimbursement, please be aware that **you are ultimately responsible for the payment of services rendered. If your insurance carrier denies payment (including recoupment) the client will be responsible for payment of all services rendered.**

CONSENT/PAYMENT FORM

This form must be completed before services can be initiated. If the client is under the age of 18 years, the form must be signed by all legal guardians.

Consent for Treatment I hereby attest that I have voluntarily applied for and entered into treatment or give my consent for the minor or person under my legal guardianship, at The Speech House. I understand that I may terminate these services at any time.

RECEIPT OF POLICIES AND PROCEDURES

I hereby attest that I have received a copy of The Speech House's Policies and Procedures, including payment policies, and have read, understand and consent to be bound by its content.

RECEIPT OF PATIENT'S RIGHTS

I hereby attest that I have received a copy of the Patient Rights notice, have read, and understand its content.

TELETHERAPY

Teletherapy services are offered for both children and adults. It is used as a primary service mode as well as a substitute when clinic visits are not possible due to various factors, including but not limited to inclement weather, unexpected change to your work schedule, transportation difficulty and illness (quarantine).

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RECEIPT OF PRIVACY POLICY AND CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

I have been provided a copy of The Speech House's Notice of Privacy Policies detailing how my medical record may be used and disclosed under Federal and State law. I understand that as a part of The Speech House's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, The Speech House may refuse to treat me. I further understand that The Speech House reserves the right to change its privacy policies and will provide me with a copy of anyrevised notice.

PHOTOCOPY AUTHORIZATION

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (Printed):_____Date:_____

Patient Signature (if over 18 years or emancipated): _____Date:_____

For minors- Legal Guardian Signature:_____Date: _____

CONSENT TO AUDIO OR VIDEO RECORDING

I consent to allowing this speech therapy session to be recorded via audio or video. I understand the purpose of this recording is to provide assessment points and tools of measurement.

I have been advised it will not be released for use in any public material or presentation.

Patient Signature (if over 18 years or emancipated):_____Date

For minors- Legal Guardian Signature:_____Date_____

Initial _____