Clearly Speaking

87 Lafayette Road Unit #3 • Hampton Falls, NH 03844
603.926.3277 • www.clearlyspeakingNH.com

Our Promise of Privacy to You

Clearly Speaking is fully committed to compliance with HIPAA guidelines:

- We provide appropriate security measures for all our patient's medical records.
- Protect the privacy of all our patient's medical records.
- Provide our parents/guardians with proper access to their child's records.
- Appropriately maintain our patient information and billing processes in compliance with the national HIPAA standards.
- Disclose copies of records to other entities for the sole purpose of treatment, only at the written request of the parent or legal guardian.
- Take all precautions necessary in protecting the right to privacy for our clients.

An unabridged version of Clearly Speaking Notice of Privacy Practices is available for your review. You have the right to review this notice prior to signing this consent. A copy of this notice may be obtained at any time.

I have been provided an opportunity to review the Notice of Privacy Practices.

Parent/Guardian's Signature:_____

Date:_____

I prefer treatment sessions to be summarized to me in one of the following...

____ in the treatment room

____ in the waiting room

*Please check one and sign our agreement below that clinicians have permission to discuss treatment progress at each session.

Signature:_____

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Speech & Language Therapy for Children
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Case History

Child's name: _____

Date of birth: _____

Pediatrician: _____

Sibling(s) and age(s):

Parent(s)/Caregiver(s) full names:

Who currently lives in the child's home (name, relationship, age)?

Where does your child currently go to school or daycare? _____

Please provide the days/times the child attends school or daycare: _____

If your child is not in a school and/or daycare program, how does he/she spend his/her day (e.g., with Grandparent, at home, etc.)?

What language(s) does the child speak at home? _____

Describe the current speech and/or language problem:

Is the child aware of the problem? _____

Is he/she motivated to improve? _____

Has your child received speech and/or language services prior to now? If yes, please list.

Is there a history of speech/language or hearing problems in your family? If so, please list.

Birth history:

Was the child born prematurely? _____ If yes, how many weeks? _____
Were there any complications at birth? _____

Medical history:

Please mark any condition that your child is currently experiencing or has experienced.

Asthma ____
Seizures ____
Tonsillitis ____
Allergies ____

Ear Infections ___ How many? _____
Has your child had his/her hearing tested? _____
When? _____ By Whom? _____

Has your child had a tonsillectomy or adenoidectomy? _____
When?

Is your child currently taking any medication?

Has your child had any surgeries? If yes, please list: _____

Does your child have any medical diagnoses? (e.g. hypotinia, seizure disorder, hearing loss).

If so, please list: _____

_____

Please list the current providers working with your child (e.g., Speech, Swallowing, OT, PT, Neurologist, Developmental Pediatrician):

Developmental history:

At what age did your child do the following?
Sit up unassisted _____
Crawl _____
Walk _____
Babble_____
Speak first word _____
Put two words together _____

Does your child have any problems related to feeding? If yes, please explain.

Does your child use a sippy cup? If yes, how long?

Does your child suck his/her thumb? If yes, how long?

Does your child use a pacifier? If yes, how long?

Do you have any other scheduled evaluations or appointments at this time?

Does your child receive any academic accommodations or additional supports in school or daycare? If yes, please list: _____

Please list your child's interests/activities: _____

_____

How would you rate your concern regarding your child's current speech challenges, 1-5?

What is your goal in regards to this evaluation and treatment?

Please summarize any additional information that you think would help us in working with your child.

Thank you for taking the time to fill out this information. We look forward to working with you and your family.

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Insurance

I am responsible for any deductibles, co- pay's (due at the time of each session), or co-insurance payments associated with my insurance benefit. I understand that all service may be subject to an auditory review even after the service has been preformed and the claim paid. I understand that I am responsible for payments not covered by my insurance plan. I understand that my insurance company will be sent an itemized bill for therapy sessions in accordance to reasonable and customary charges. I understand that I must notify Clearly Speaking, LLC of any insurance changes immediately. _____(Initial)

It is the responsibility of the patient to verify coverage of services. For insurance holders that require a referral, you must contact your primary care provider and inform them that you have been referred to Clearly Speaking, LLC. This should be done prior to your child's first visit. If you have not followed these procedures and would still like to have your child seen, please understand that you will be responsible for any charges incurred if the referral is denied. _____ (Initial)

I understand that any information gained from insurance companies during verification of benefits, however, is not always guaranteed. It is imperative that families are aware of their insurance coverage and their potential responsibilities. _____(Initial)

_____ _____

Patient name printed Date of birth

_____ _____

Signature Date

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Request for Exchange of Information

I give permission to exchange information (medical records, school records, progress notes, evaluations), regarding my child _____ between Clearly Speaking, LLC and the following facilities:

1. Name of facility:_____

   Address: _____

2. Name of facility: _____

   Address: _____

3. Name of facility: _____

   Address: _____

_____ _____
Signature Date

HIPAA NOTIFICATION

I am required by law to maintain the privacy of protected health information, give you a notice of our legal duties and privacy practices regarding health information about your child, and follow the terms of the attached notice.
By signing this document you acknowledge receipt of the privacy policy as it relates to protected health information about your child's treatment, payment and health care operations. You have the right to request restrictions, which must be made in writing to Clearly Speaking, LLC, 87 Lafayette Rd. Unit 3, Hampton Falls, NH 03844.

_____ _____
Signature Date

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Financial Agreement

I am responsible for payment of all services rendered by Clearly Speaking if/when they are not covered by insurance. I give the right to Clearly Speaking to submit relevant personal information to my health insurance to submit a claim. I understand that if my insurance denies a claim or coverage runs out that I am financially responsible. It is my responsibility to gain information regarding my policy and it's coverage of speech and/or language services. Payment in full is due within 30 days of service. The guarantor of the patient will be responsible for all late, collection and/or attorney fees if necessary. Parent(s)/Guarantor will be responsible for all late, collection and attorney fees if necessary.

Payment
Co-pays and treatment fees are due at time of service. Clearly Speaking accepts all major credit cards. Please make checks payable to Clearly Speaking, LLC.

Cancellations
Please provide Clearly Speaking with notice of cancellation more than 24 hours of a scheduled appointment. Cancellations that occur within 24 hours of the scheduled appointment will be charged $60 (this fee will not be covered by insurance). Any scheduled appointment missed without notice will be be charged $60. Clearly Speaking reserves the right to terminate treatment if there are three missed scheduled sessions.

_____ _____

Signature Date

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Ongoing Authorization to Charge Credit Card

I hereby request and authorize Clearly Speaking to charge my credit card for all current and future amounts when due. Any appointment that is missed without 24 hours notice will be charged a fee of $60.

Card Type ( ) Visa ( ) Master Card ( ) Discover

Name on Card

_____

Card Number

_____

Verification (CVV) Number

_____

Expiration Date

_____

Card Billing Address

_____

City_____
State_____Zip_____

Authorized by (Print Name)

_____

Signature _____
Date_____