



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: _____



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 attend school? _____

What grade is your child currently? _____

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 yes, please explain.

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? If yes, please list.

Please list any medical diagnoses your child has been given (e.g. hypotonia, seizure disorder, hearing loss): _____

Has your child had any surgeries? If yes, 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 _____

Speak first word _____

Babble _____

Put two words together _____

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

Does your child have an individual education plan (IEP) at school?
If yes, what are the areas of concern?

Does your child receive any special accommodations or additional supports in school? If yes, please list type and frequency.

Does the child currently receive any special services? If yes, please list.

Does your child have any other scheduled evaluations at this time?

What are 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 child.



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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 performed 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 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 _____