

## **Celebrations Speech Group Inc.**

Speech and Language Therapy

201 Sand Creek Rd Suite G-4 Brentwood, CA 94513 Ph 925-529-4790 Fax 925-401-9510  
[www.celebrationspeechgroup.com](http://www.celebrationspeechgroup.com)

### **Welcome to Celebrations Speech Group Inc. Speech and Language Therapy!**

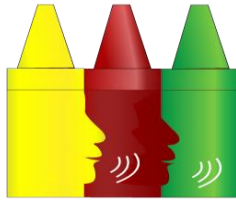
Thank you for choosing Celebrations Speech Group Inc. to help your child achieve and improve their communication abilities. We sincerely appreciate this opportunity, and look forward to working with you and your child.

The attached new client paperwork packet includes important information about our practice and services. Please take the time to fill out and review our clinic policies. A client history form is included to provide information that will be vital for the direction of your child's therapy plan. Additionally, if your child has had any recent assessments completed by other health professionals i.e.(psychologist, an IEP, etc.), please provide these copies or email them to the clinic prior to services beginning.

We look forward to working with you and your child!

Sincerely,

*Staff*  
Celebrations Speech Group Inc.  
(925) 529-4790



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Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Referring Physician: \_\_\_\_\_

Client Name (First, Middle Initial, Last): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ SSN: \_\_\_\_\_

Parent/Guardian 1 Name (First, Middle Initial, Last): \_\_\_\_\_

Parent/Guardian 2 Name (First, Middle Initial, Last): \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Preferred Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

## **Complete all Insurance Information Below**

Primary Insurance: \_\_\_\_\_

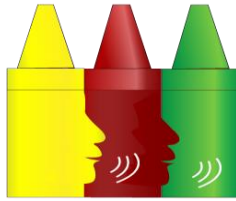
Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client's Relationship to insured: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_ Insured SSN#: \_\_\_\_\_

Insured's Policy or Group#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_



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### **ATTENDANCE**

Consistent attendance is the foundation for helping a child make progress in therapy. It is the parent/guardian's responsibility to ensure that a child receiving services **DOES NOT** miss therapy sessions frequently. If a child misses 6 or more appointments in a 6 month period, Celebrations Speech Group Inc. reserves the right to discontinue treatment or place the client on a waiting list.

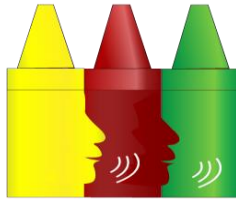
**Please note** appointments missed for 2 or more weeks in a row within a 6 months period may result in the loss of your therapy time slot. If a client intends to be gone for more than 2 weeks in a row and would like to keep their therapy time slot, they may choose to pay in cash at a rate of 50% of the normal session fee for the sessions that will be missed in order to reserve their spot. Otherwise, the client will need to contact the clinic upon returning in order to secure another appointment time or is wait listed.

### **CANCELLATIONS/NO SHOWS/LATE**

Our cancellation policy is very important so please read this section carefully to ensure we are effectively planning the quality time to meet the needs of "you" our clients. Celebrations Speech Group Inc. requires at least a 24 hour notice of cancellation. In addition make-up sessions are required and will be scheduled for missed appointments within a client's insurance authorization period. We are available by phone at (925) 529-4790, or highly preferred please contact your therapist directly should you need to cancel and reschedule a session. Late cancellations or "No-Shows" appointments will be charged a \$25 fee for insurance paying clients (except Kaiser), and 60% of your normal session rate for cash paying clients.

Our clients are very important to us therefore we take all means to ensure that everyone is given quality service. This includes prompt beginning and ending of treatment sessions. **Please note:** if you are late for your scheduled appointment, you will only be treated for the remaining time of your session. The fees for services WILL NOT be adjusted. If for any reason the therapist is running behind, you will be granted your full treatment time and/or offered make up sessions at your convenience.

**Make-Up Policy:** If any of your sessions require make-up services as agreed, make-ups will be scheduled on a space available basis. Please inform your therapist of any planned absences or cancellations as soon as you are aware of them.



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### **PAYMENTS**

**Insurance Pay** Co-payments, co-insurance, or deductibles will be collected at time of service. It is advised by our clinic and best practice that you are familiar with your insurance company on what your co-payments, co-insurance or deductible amounts are prior to beginning treatment in our clinic to ensure an efficient and accurate billing procedure.

In the event your insurance denies payment for services rendered, **please note you are assuming full responsibility of those services rendered.** In addition, it is your responsibility to notify the clinic immediately of any changes to your insurance or coverage changes.

**Cash Pay** Cash paying clients will pay for services at the time of services. Payments can be paid by cash or check. **Returned checks will incur a \$35 return fee.**

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I have read and agreed to all Celebrations Speech Group Inc. Clinic policies.

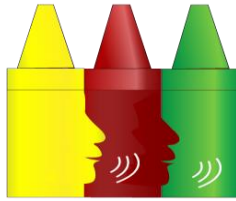
\_\_\_\_\_  
Signature of Client, Parent, or Guardian Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS**

I authorize Celebrations Speech Group Inc. to submit claims for payment for services to my health care service plans or insurance companies, on my behalf and in the name of the client named below. This authorization shall remain in effect as long as the client named below receives service from Celebrations Speech Group Inc.

**I understand that I am financially responsible for any charges not covered by the group insurance benefits.**

Name of Client: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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Signature of Client, Parent, or Guardian

**AUTHORIZATION AND CONSENT**

By signing this form you are also agreeing to the following:

1. You understand that unresolved financial disputes for non-payment of fee for services rendered could result in the discontinuation of services, referral to another provider as necessary, and assignment of collection responsibility for this account to a professional agency.
2. You agree that any and all fees are the responsibility of you, the parent/guardian, including those not covered by insurance or other sources. It is the sole responsibility of the parent/guardian to determine whether continued coverage is available for the child's speech therapy.
3. You, the parent/guardian have read, understand, and agree to aforementioned policies and financial agreement that will be implemented immediately as set forth for services rendered by Celebrations Speech Group Inc.

Client Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Client Parent, or Guardian

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMAITON**

I authorize Celebrations Speech Group Inc. to release to hospitals, health care service plans, insurance companies, self-insurers, or their representatives, any or all records. Records would be medical history, treatment, or any services rendered, that is needed to review, investigate, or evaluate any claim for benefits.

Client Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Client, Parent, or Guardian



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### **CONSENT TO PHOTOGRAPHS OR RECORDINGS (CHECK ALL THAT APPLY)**

- \_\_\_\_\_ I grant Celebrations Speech Group Inc. the right to photograph or take video of my child for use in clinical observation or for placement in marketing materials (website, flyers, clinic walks, etc.)
- \_\_\_\_\_ I grant Celebrations Speech Group Inc. the right to photograph or take video of my child for clinical use only.
- \_\_\_\_\_ I prefer that no photographs or video recordings of my child be taken.

Clients Name: \_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

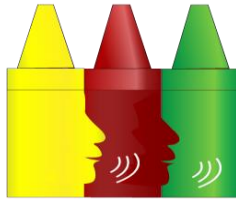
\_\_\_\_\_  
Signature of Clients, Parent, or Guardian

### **Communication**

We frequently communicate through email and text regarding schedule changes and progress updates if you are not available to discuss the matter in person or if a last minute change occurs.

Do you give us permission to communicate with you via email? YES \_\_\_\_\_ NO \_\_\_\_\_  
If so, which email address would you prefer to use? \_\_\_\_\_

Do you give us permission to communicate with you via text? YES \_\_\_\_\_ NO \_\_\_\_\_  
If so, which phone number would you prefer to text? \_\_\_\_\_



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### **CONFIDENTIALITY/HIPPA NOTIFICATION**

In general, the privacy of all communication between a client and a therapist is protected by law, and can only be released to others with your written permission. In accordance with HIPPA law and HIPPA privacy policies and procedures.

I have read and received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Client, Parent, or Guardian

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

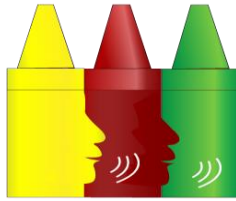
### **HIPPA Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW ALL POINT BELOW CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information. Your protected health information may be used and disclosed by your physician, therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operations of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health



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information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval/ payment for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval/payment for the treatment.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of new employees/staff, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to new therapists/staff that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your treating provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Disease Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our Compliance with the requirements of Section 164.500.

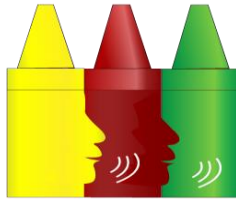
Other permitted and required uses and disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician, provider, or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization

**Your Rights–** Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information

You have the right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action





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or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician/ provider is NOT required to agree to a restriction that you may request. If the physician/ provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician/ provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you via mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your provider of your complaint. We will not retaliate against you for filing a complaint.