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

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

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

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 therapy plan. Additionally, if you have had any recent assessments completed by other health professionals i.e.(psychologist, an audiologist, etc.), please provide these copies or email them to the clinic prior to services beginning.

We look forward to working with you!

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: _____

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Insured's DOB: _____/_____/_____

Client's Relationship to insured:

_____

Insured's ID#: _____

Insured SSN#:_____

Insured's Policy or Group#:_____

Emergency Contact: _____

Phone #: _____

ATTENDANCE

Consistent attendance is the foundation for helping a client make progress in therapy.
If a client 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 (due to a vacation or a prolonged illness) 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 cancelation 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 and a make-up session will be scheduled. We are available by phone at (925) 529-4790, or highly preferred contact your therapist directly should you need to cancel and reschedule a session. Late cancelations or "No-

Shows" appointments will be charged a $25 fee for insurance paying clients, 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.

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.**

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

_____

Date: _____/_____/_____
Signature of Client, Parent, or Guardian

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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:_____/_____/_____

_____
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 your responsibility, including those not covered by insurance or other sources. It is the sole responsibility of the client to determine whether continued coverage is available for speech therapy.

3. You 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

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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

CONSENT TO PHOTOGRAPHS OR RECORDINGS (CHECK ALL THAT APPLY)

_____ I grant Celebrations Speech Group Inc. the right to photograph or take video of me 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 me for clinical use only.

_____ I prefer that no photographs or video recordings of myself be taken.

Clients Name: _____ Date:_____/_____/_____

_____
Signature of Client, Parent, or Guardian

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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?
_____

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.

_____ Date:_____/_____/_____
Signature of Client, Parent, or Guardian

HIPPA Notice of Privacy Practices

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

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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 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
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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

<u>You have the right to inspect and copy your protected health information.</u>
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.

<u>You have the right to request a restriction of your protected health information.</u> 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.

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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.