
SPEECH THERAPY ASSOCIATES, LLC

# Consent for Services

Our master company's name is, Our Friends Speech Therapy. Please be aware that we are doing business as (DBA) Speech Therapy Associates LLC under our master company's name. Therefore, our master company name may appear on billing information or in the Step Up Scholarship portal. Signatures in this package indicate that you are granting permission for both Our Friends Speech Therapy and our DBA of Speech Therapy Associates LLC. Please complete the form below to grant permission and authorize a screening, comprehensive speech and language evaluation, and/or treatment (as needed) for your loved one. A screening is a brief assessment used to determine whether further evaluation is needed. Speech-language evaluations consist of standardized testing, informal and formal observations, and clinical judgment.

If the Speech-Language Pathologist finds it necessary to conduct a formal screening, you will be contacted regarding the results of the screening. A complete evaluation and/or subsequent treatment will be administered after your therapist has discussed the results of the screening if applicable. Our administrative assistant will discuss any relevant fees or insurance considerations. If an evaluation is agreed upon, a state-licensed and certified speech-language pathologist will administer the evaluation (including standardized evaluation tests, language samples, caregiver interviews, etc.). If speech-language therapy is warranted, your therapist will discuss the planned treatment course for your loved one, informed by the evaluation results as well as parent/caregiver input. If you have any questions, your therapist will be happy to discuss them with you during this process.

**By signing below, I authorize Speech Therapy Associates LLC to screen, evaluate and/or provide the necessary speech and/or language therapy to the individual listed below.**

Your Signature: _____ Date: _____

Client Name: _____ Relationship to Client: _____


SPEECH THERAPY ASSOCIATES, LLC

# Informed Consent Form

I, _____, the parent/legal guardian of _____, hereby request and consent to Speech Therapy Associates LLC providing treatment and care as prescribed by a physician and/or recommended by a speech-language pathologist.

For minor children, I acknowledge and agree that a parent or legal guardian must be present (in the home for home-based visits or in the waiting area of the office for clinic-based visits) during each treatment session and for the entirety of the session. I am aware that I am required to drop my child off five minutes before my child's session and be present to retrieve my child five minutes before the end of their scheduled session at the clinic. I may not leave the parking lot structure of Speech Therapy Associates while my child is being treated.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize Speech Therapy Associates LLC to administer treatment under the direction and supervision of a certified Speech-Language Pathologist.

Parent/Guardian Signature _____ Date _____

SPEECH THERAPY ASSOCIATES, LLC

# Speech Therapy Intake Form-Child

Person completing form: _____ Relationship to child: _____ Date: _____

Child's name: _____ DOB: _____ Gender: _____

How did you hear about our clinic? _____

*Thank you for taking the time to fill out this form as completely and accurately as possible. We value your role in the evaluation process to help us determine the most appropriate treatment for your child. All responses are confidential and will not be released without your permission. Please answer to the best of your knowledge and mark "N/A" for any questions that do not apply to your child.*

## Medical Information

Child's primary care physician: _____ Date of last doctor's visit (approx.): _____

Is your child currently under the care of any other medical specialists such as a neurologist or audiologist?

If so, please list: _____

Please list any medical diagnoses your child has: _____

Please list any medications your child currently takes:

_____ Please list any allergies your child has:

_____ Please describe any developmental delays your child is currently experiencing or has experienced in the past *(such as delays with walking, saying first words, potty training, etc.)*:_____

_____

Were there any birth or pregnancy complications? _____

Is there a family history of speech-language delays or disorders, autism, learning disabilities, or mental health diagnoses? If so, please describe: _____

_____

## Social/Educational Information

Does your child attend school or daycare? _____ Current grade: _____ Grades repeated? _____

School or daycare name: _____

Special services received at school *(such as special education classes, speech therapy, occupational therapy, physical therapy)*: _____

Special services received outside of school *(such as speech therapy at a clinic, ABA therapy, hippotherapy)*:

_____

Does your child experience difficulties at school (socially or academically)? If so, please describe:_____

_____

Has your child's teacher mentioned concerns about his/her speech/language skills, social skills, behavior, or academics? _____

Family Information

Mother's Name: _____ Best contact phone #: _____

Father's Name: _____ Best contact phone #: _____

If applicable, please list other family members who regularly care for your child: _____

_____

Please list family members that your child lives with, including siblings and their ages:

_____

What is the child's dominant language? _____

Speech/Language/Swallowing

*Please describe specific speech, language or swallowing concerns in the appropriate answer section below.*

Do you have concerns about the way your child pronounces words, or about your child's ability to be understood? _____

Does your child have difficulty understanding what is said to him/her?_____

_____

Does your child have difficulty expressing him/herself *(such as forgetting words, using incorrect grammar, or difficulty retelling a story)?* _____

_____

Does your child stutter or repeat words multiple times when trying to speak? _____

_____

Do you have concerns with your child's voice quality *(such as chronic hoarseness or breathiness)*?

_____

Does your child have difficulty with feeding, chewing, or swallowing? _____

_____

Is there anything else you would like us to know about your child or about your reasons for seeking speech therapy services? _____


SPEECH THERAPY ASSOCIATES, LLC

# HIPAA Privacy Notice

This HIPAA (Health Insurance Portability and Accountability Act) Notice describes how speech-language therapy information and other relevant medical information about you/your child may be used and disclosed and how you can get access to this information. Please review it carefully.

## Commitment to privacy

We are dedicated to protecting your privacy and health information. In serving our patients, and to comply with applicable laws, we create records regarding evaluation and treatment. We are required to keep this information safe and secure. We will only share your information in accordance with state or federal law and in keeping with ethical standards of practice.

Types of personal health information we may collect and store:

- Notes from doctors, teachers, or other healthcare providers
- Evaluation results
- Treatment plan, notes, and results
- Medical history
- Insurance information

How we might use and share this information:

- To provide treatment
- To share with other medical professionals involved in your care
- To run our practice, including billing for services
- To do research or help with public health and safety issues
- To comply with the law, including disclosures if abuse or neglect is suspected

You have the right to:

- Receive a copy of your paper or electronic treatment records
- Request corrections to information collected about you
- Request confidential communication
- Ask us to limit the information we share (especially with regard to how information is shared with your friends and family or when marketing our services)
- File a complaint if you feel your information has been shared in a way that violates HIPAA policies

Requests must be made in writing and not all requests can or will be fulfilled.

We must inform you before we share your medical information in a way that is not mentioned in this notice. This HIPAA policy is subject to change and we will provide you a copy of the updated notice. If you have any questions, please ask your speech-language pathologist.

I HAVE READ AND UNDERSTOOD THE PRIVACY POLICIES DISCLOSED IN THIS NOTICE

Your Signature: _____ Date: _____

Patient Name: _____ Relationship to Patient: _____

SPEECH THERAPY ASSOCIATES, LLC

# Speech Therapy/Social Skills Lessons Agreement

## PAYMENT POLICY

Speech Therapy Associates LLC currently accepts only private/out-of-pocket payment, the Step Up Scholarship, CIGNA, Aetna commercial, full medicaid, Tricare, Health Network One, Aetna Better Health, Simply Healthcare Plans, and Healthy Kids insurance. It is the responsibility of the parent or guardian to file all insurance claims if you so choose for insurances we do not accept. We will provide all clients with a detailed invoice for services rendered related to speech-language therapy that can be submitted for insurance claims by the parent and/or guardian upon request. We do not provide super bills for social skills lessons as these are not covered by insurance. We will also provide additional information on services rendered upon request should your insurance carrier require more information beyond the invoice. Please note that it is the responsibility of the parent and/or guardian to contact their insurance carrier to determine the required documentation for filing insurance claims. Patients will be billed on the same day as services rendered. Payment is due on the same day as the services are rendered. Failure to make any payment will result in your child's services being put on hold until payments are received and your account is paid in full. If you pay by check, credit, or debit card and the payment bounces, you will be charged a $35.00 fee. A convenience fee of 3.5% will be automatically applied to all payments made through credit or debit cards for using our card reader. Our initial speech-language evaluation rates are $150.00 and re-assessments are $100.00 both in the clinic and in the community (home setting). Our one hour speech-language sessions are $90.00, half hour sessions are $65.00 in the clinic, Social skills lessons are $60.00 per hour provided in the clinic. Our community rates are higher to compensate for mileage and treatment time lost by commuting. One hour speech-language sessions are $150.00 and social skills lessons are $75.00 in the community setting available for private pay patients only and limited by restricted availability. Discounts and promotions will be applied at the discretion of Speech Therapy Associates LLC.

## CONTACT & SESSION DETAILS

You can reach us by phone at 863-421-5800 or email us at speechtherapyassociatesfl@gmail.com. If you have questions about therapy or social skills lessons, please communicate these in a timely manner during the next visit or via phone. If you notice changes and improvements, please share them! Progress can be celebrated and new goals can be developed to maximize therapy time. A session may last 30 or 60 minutes and may occur once or twice a week depending on therapist recommendation and parent input. This is time spent with the patient directly working on therapy goals and can include consultative time with the caregiver. The time that we schedule for you is yours, and we value that time. Please be aware your clinician reserves the right to end the session 5 to 7 minutes early to sanitize their therapy rooms and transition the patient. We appreciate your understanding as we strive to maintain a clean and healthy environment.

# CANCELLATION & NO-SHOW POLICY

Missed Sessions/Cancellation Policy: We request that you notify us 24 hours prior to your appointment if you need to cancel or reschedule. Failure to call or be present for an appointment is considered a missed appointment. We will charge the patient or the responsible parent/guardian the rate of a normal visit for all missed appointments after 2 allowances. Please note that insurance providers do NOT reimburse for missed appointment charges. If your child misses 3 or more therapy sessions within a 6-week period, we reserve the right to place your child's services on hold until scheduling conflicts are resolved. A consistent schedule is pertinent to your child's progress in speech-language therapy. Please help us by keeping scheduled appointments or calling at least 24 hours prior to reschedule.

Illness Policy: If your child has a fever, a persistent cough, or a runny nose, please call and cancel your appointment. If a child has been on an antibiotic for 24 hours and does not have a fever, is not coughing frequently, and does not have a runny nose, he/she is probably not contagious. We appreciate your understanding and will be happy to reschedule your appointment. Feel free to call us at any hour and leave a message. We appreciate three hours notice if you are canceling; however, we also understand how illness in young children can occur suddenly, so you will not be penalized with a fee if you call and cancel for sudden illness as long as medical documentation is provided. We reserve the right to request medical documentation to support absences due to illness in order to count this as an excused absence.

## Social Skills Lessons:

Please be advised that our social skills lessons are based on the educational model. These sessions are not a substitute for speech-language therapy treatment. They are not based on the health service model. These goals are educationally based and specifically tailored to meet the unique social skills needs of each child. Your signature at the bottom of this form indicates you understand that social skills lessons are educationally based. Typically, we recommend 6 months of social skills lessons to optimize results, however we reserve the right to dismiss the child from these services if they meet their social goals ahead of time or if they no longer benefit from the program. Our cancellation and no show policy also applies to social skills lessons.

## PERMISSION TO EVALUATE AND/OR PROVIDE THERAPY/PROVIDE SOCIAL SKILLS LESSONS

I, _____, authorize Speech Therapy Associates LLC, to evaluate
(parent/guardian)
and/or provide the necessary speech and/or language treatment services/social skills lessons/
to _____.
(child's full name)

Treatment is based upon the findings of the evaluation and the recommendations of the responsible speech-language pathologist.

You will be contacted regarding the results of your child's speech-language evaluation. Results of the evaluation will determine a treatment plan that will include the recommendations of the speech-language pathologist and input from the parent.

As the parent or guardian, I have read the above information and understand Speech Therapy Associates LLC Payment Policy, Cancellation and No Show Policy, and Permission Statement. I accept all terms and conditions.

*Parent/Guardian Signature Date* _____

*Parent/Guardian Printed Name* _____

SPEECH THERAPY ASSOCIATES, LLC

# Social Skills Lessons Agreement Authorization to Release Information

Patient Name: _____ DOB: _____

Street Address: _____ City/State: _____Zip:_____

I understand this release is voluntary and applies to all programs and services operated under Speech Therapy Associates LLC. I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. I understand that I may revoke this authorization at any time by notifying Speech Therapy Associates LLC in writing, but if I do, it will not have any effect on any actions taken before receipt of the revocation. This release once signed will remain in effect unless otherwise revoked.

I hereby authorize Speech Therapy Associates LLC to: Exchange, release, and obtain information from: employees of Speech Therapy Associates LLC, my child's medical provider, and my child's school or related personnel.

This information is to be used for diagnostic, treatment planning and continuity of care purposes only.

*Parent/Guardian Signature Date* _____

*Parent/Guardian Printed Name* _____

Speech Therapy Associates LLC

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