

Speech Pathways

Therapy Services for Pediatrics and Adults

Upon reading the following policies, please download, fill out, and return the following acknowledgement form:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include speech therapy for articulation, language or swallowing.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose you're protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the

threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Speech Pathways
1118 North Chinowth Street, Visalia, CA 93291

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights

200 Independence Avenue, S.W., Washington, D.C. 20201
877-696-6775 (toll-free)

Payment Policy

- We accept Visa, MasterCard, Discover, Checks and Cash payments at the time of service. For all Non-Sufficient Fund (NSF) returned checks, a \$20 charge will be incurred above the amount of the check.
- As a service to our clients we bill insurance on a weekly basis. Clients are responsible for their charges.
- Late arrivals will be charged the full session regardless of the time spent in therapy.
- Missed sessions without notification or telephone call will incur a \$60 "No Show" charge.. Please be aware that "No Show" charges cannot be billed to Insurance or other third party payer.
- Therapy sessions cancelled by the client will not incur "No show" charges if notice is provided 24 hours in advance. Payments may be made in advance and may be eligible for discount if the entire month's appointments (minimum 4 sessions) are paid.
- Check-In and Payment is required before the therapist will see the client.
- We understand from time to time, payment is not possible at the time of service. If you need to make payment arrangements please speak with us. An account balance of \$300.00 or more will result in a temporary hold on therapy until the balance is paid off. If your account is 90 days past due, it will be turned over to a collection agency for management and collection. Additional fees will be added.
- It is your responsibility to inform the office if there is an insurance change and provide the office with the new insurance card. Any treatment provided without the current insurance information on file prior to your appointment will be your responsibility.
- Speech Pathways will provide you with a copy of the Assessment report provided the assessment fee has been paid. No reports will be issued until the assessment fee has been paid.

Insurance Policy

- Every calendar year deductibles need to be met. If you have a deductible that needs to be met, please pay for your sessions in full or you can pay your entire deductible at once. Once your deductible is met, please keep in mind you are still responsible for any co-payments, which are to be paid at check in.
- There may be a delay in payment from out-of-network insurance companies; however, the client, parent, or guardian is ultimately responsible for payment. If
- Insurance pays on those outstanding billed dates, the responsible party will be reimbursed unless otherwise requested in writing that the refund be kept in the account to cover future co-payments and deductibles.
- If your insurance company rejects the claim for services initially we sometimes are able to provide additional information indicating medical necessity for the service.

Appointment Policy and General Office Policy

- Policy states that if there are 3 consecutive missed appointments or if you miss 30% or more of your scheduled appointments over a 2-month period you will be removed from the schedule. It is critical for progress to attend 70% or more of your treatment sessions. Once removed from the schedule, that time slot is available to schedule other clients. We will attempt to notify client, parent, or guardian by telephone or by letter about the removal. However, the client, parent, or guardian will be responsible for contacting our office, if they wish to continue or resume services and will also be requested to sign a commitment agreement.
- Therapy sessions are scheduled for one hour or 30 minutes. Actual therapy time is 50 minutes for the hour session and 25-minutes for the 30-minute session. The remaining time is for parent contact and charting.

- We offer consultations for a \$50 fee. If an assessment is scheduled as a result of the consultation, the \$50 will be applied towards the assessment fee.
- Frequently it is advantageous to have parents observe or participate in therapy sessions, if it is not distracting to their child. . Attending therapy sessions or observing facilitates follow-through in the home environment and can result in faster progress.
- At this time, we ask that parents do not leave while their child is in therapy. If you choose not to be in the therapy room, please make yourself comfortable in our reception area. If you plan on waiting outside or in your car, please inform the therapist.
- Please have your child wear comfortable clothing for moving around. From time to time we may do activities that are messy. Please have your child wear clothing that may get dirty during therapy.
- Please monitor all siblings while in the waiting area. Safety of all family members is important to us as well as providing a calm and comfortable environment for everyone.
- Most importantly, we value you and the trust you have placed in our service. Any suggestions or feedback that might facilitate a more efficient and clinical environment are most welcome.

I have the read the above and hereby accept all responsibility for the evaluation and treatment costs incurred by my child or myself. The undersigned certifies that he/she is the responsible party and accepts these terms. I certify that any and all information given by me to Speech Pathways is correct to the best of my knowledge. I agree that a copy of this form shall be valid as the original and will not expire.

I authorize the release of any medical information necessary to process the insurance claim. I further authorize payment of medical benefits to Deborah DeLong DBA as Speech Pathways.

Responsible Party

Date

Printed Name

Childs Name (if applicable)