Speech Pathways

Therapy Services for Pediatrics

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 regard 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
1017 N Demaree 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 $65 “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.
- 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 30 minutes. Actual therapy time is 25 minutes . 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.
- Currently, 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.

<u>PLEASE NOTE:</u> On occasion, our therapists will need to be out of the office due to illness or vacation. During this time, we will make every effort to reschedule all appointments with another therapist on the same day, or at the next available opening. While we strive to keep your child with the same therapist, it is not always possible. We request that each family be flexible during these times, we assure that all our staff are qualified and have extensive experience working with children. To become acquainted with our therapists and staff, please visit our website: www.speechpathwaysca.com. For all scheduling concerns, please contact the office.

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)

Speech Pathways

Therapy Services for Pediatrics

CONSENTS AND ACKNOWLEDGEMENT FORM

Consent for Care and Treatment: I hereby consent to speech-language evaluation, procedures
and/or treatments prescribed to my child or me by the Speech-Language Pathologist. I hereby
understand that the recommendations made by the Speech-Language Pathologists were based on
clinical observations, assessment information, and information provided by me. I understand that
providing accurate information to the Speech Pathologist is necessary in order for the SLP to develop
an appropriate plan of care. I authorize release of medical information to Speech Pathways for
continuity of care. I acknowledge that speech Pathways has not made any guarantee or warranty as
to the results of any services or treatments given.
Acknowledgement of Notice of Privacy Practices: I acknowledge Speech Pathways will use and

disclose my personal health information or that of my child's for treatment, payment, and other
healthcare operations and as otherwise permitted by law. Out notice of Privacy Practices provides
further detailed information about how we use and/or disclose protected medical information about
you or your child for treatment, payment and healthcare operations, and as otherwise allowed by
law. I acknowledge that I have received a copy of the Privacy Practices.

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Signature Date

Criteria for Therapy Services In-Home at the Naval Air Station Lemoore

1. The initial assessment must be completed in our office. If your child has had an assessment done within 6 months, then all you will need to do is forward a copy of the initial assessment report to our office and we will be able to develop a treatment plan. If your child has a school IEP that is 6 months old or less, we will not need to do an assessment in the office. An assessment will need to be done if your child has never had an assessment OR if the prior assessment or school IEP is more than 6 months old.
2. Therapy sessions will need to be conducted in a quiet/semi-quiet area of the home. This can be at the dining table, living room, or a home office. We encourage parents

to be a part of the therapy session if possible, however, siblings cannot be part of the therapy sessions unless it serves to benefit the child receiving the therapy. There are occasions when children participate more in therapy when a sibling is part of the session. We bring our own therapy materials, but ask that you have 1-2 favorite toys or activities that will serve as reward/motivation for your child.

3. Please notify our office as soon as possible if you are not able to keep your appointment for the day. On days when we have cancellations, we may call the remaining families to see if you are able to move your appointment ahead or back a few minutes. We do this in order to avoid too much down time while the therapists are on base. We do understand if you are not able to adjust your appointment time on those days we have cancellations and we will then keep your appointment as scheduled.
4. In-home therapy services are rendered at the discretion of the attending therapist and can be discontinued if the criteria are not met or if we feel that in-office services would be more beneficial to the child. Please be advised that if progress is not being made, or our services are not effective in enhancing the child's communication skills, we reserve the right to suspend or discontinue speech services.

I have read and understand the above criteria for receiving in-home speech therapy services.

Parent Signature Date

Speech Pathways

Therapy Services for Pediatrics

INTAKE FORM

DEMOGRAPHIC INFORMATION

Child's Name ____ Date of Birth ______________

Child's nickname (if applicable) ____________________________ Gender ____________ Age _______

Parent/Guardian ____ Home Phone____________________

Address____ Cell Phone of Mother___________

City/State/Zip____ Cell Phone of Father_____________

E-Mail Address ____ Work Phone_____________________

Siblings _______________________________ Age_____ Siblings ____________________________ Age_____

Siblings _______________________________ Age_____ Siblings ____________________________ Age_____

Emergency Contact: ____ Phone_________________________

Reason for Referral/Concern: ____

PRIMARY INSURANCE INFORMATION

Provider ____ Employer's Name _________________________

Insured's ID Number _______________________________ Insured's Group Number____________________

Child's Relationship to Insured_______________________ Insured's SSN: ____________________________

Insured's Full Name: _______________________________________ Date of Birth: ______________________

SECONDARY INSURANCE INFORMATION

Provider ____ Employer's Name _________________________

Insured's ID Number _______________________________ Insured's Group Number____________________

Child's Relationship to Insured_______________________ Insured's SSN: ____________________________

Insured's Full Name: _______________________________________ Date of Birth: ______________________

MEDICAL INFORMATION

Primary Care Physician____ Phone____________________

Address: ____

Medical Specialists (if any)
Name____
Specialty__________________________________

Name____
Specialty_________________________________

Name____
Specialty__________________________________

HEALTH AND DEVELOPMENTAL HISTORY

Maternal History
Did mother take medication during pregnancy? (Please specify what, why and for how long)
____
_____
____
_____
____
_____

Did any of the following occur during pregnancy?

___Bleeding____

___Measles____

___Illness/Infections____

___Rashes____

___Rh incompatibility of parents______________________________

Birth History
Length of pregnancy (weeks) ______________Labor induced ________________ Forceps used__________

Birth weight____________________ Apgar Score___________________ Length of Labor_______________

Any medications given during birth and to whom
____

Explain any significant occurrences during the child's birth (i.e., trauma, cord wrapped around neck,
jaundice, heart issues, feeding problems, need for medical attention/oxygen):

____
____
____

HEALTH HISTORY

Has the child's health been good, fair, or poor?
____

Please circle any of the following occurrences:

Ear Infections Eczema Constipation Allergic Reactions
Tubes in Ears Asthma Special diet
RSV/Pneumonia Reflux Seasonal Allergies
Takes medicine regularly (frequency/reason):
____

Hospitalizations:
____
Surgeries:
____

Developmental History

At what age did the child reach the following developmental milestones?
Sit unsupported: ________ Crawl: ___________ Walk: ___________ Bladder Control:
____
Bowel Control: __________ Feed Self: _________ Stand: _________ Dress Self:
____
Begin saying words: _________ Combine words: ____________
Answer questions/relate information verbally: ________________

Compared to sibling or peers, was speech development fast, slow or
average_____________________

Does the child seem to be aware of his/her speech-language
challenges_________________________?

How does the child usually communicate? (Gestures, signs, single words, phrases, sentences)

How much do you understand your child's speech
____?
Do others understand your child's speech___________________ How
much_________________________
Languages used:
At Home _______________________________________ At
School_________________________________

Primary Language child
uses____

Concerns (Please check all that apply)
___Hearing (has a hearing loss, seems to not hear information, need repetition)
___ Speech Articulation (difficult to understand or poor sound production)

___Expressive Language Skills (unable to relay thoughts or express needs clearly)

___ Receptive Language Skills (difficulty following directions or concepts)

___ Oral Motor Functioning (drooling, tongue thrust, muscle strength)

___Swallowing/Feeding (cough/chokes with food, decreased chewing)
___Other (Please Explain)
____

ASSOCIATED ILLNESS OR DISORDERS
(Please check all that apply and indicate M-mother, F-Father, S-sibling of child, or R-other relative)
___ Hearing Loss ___ Intellectual Disability
___ Clinical Depression ___ Mental Illness
___ Autism ___ Alcoholism/Drug Abuse
___ Seizures/Epilepsy ___ Other (please specify)
____

EDUCATIONAL AND SOCIAL HISTORY

Is the child currently attending a school or preschool__________ Name:
____

Grade_____________________
Teacher____

How is your child doing academically or pre-academically______________________________________?

How does your child interact with others? (Shy, aggressive, uncooperative, outgoing, and friendly)

____

Previous/current therapy providers through school or any other setting:

Name________________________________Service________________________ Date _______________

Name________________________________Service________________________ Date _______________

Name________________________________Service________________________ Date _______________

Please circle the most appropriate response that describes your child:
(Frequently (F), Occasionally (O) Never (N))

Is distracted/has trouble functioning with noise present………………………….. F O N
Does not hear what you say (tunes you out or ignores you……………………….. F O N
Does not respond when name is called……………………………………………...………. F O N
Cries or covers ears when loud noises are present……………………………………….. F O N
Enjoys music and noise and uses it to calm down…………………………………………. F O N

FEEDING/ORAL-MOTOR HISTORY
Was the child breast fed__________ How long________ Bottle fed _________ How long ___________

Has/does the child currently display any of the following difficulties?

Choking/gagging _____ Over stuffing of food _____ Spits out food _____
Drooling_____ Special diet _____ Poor chewing _____
Swallows food whole_____ Sticks tongue out when eating _____ Food allergies _____
Difficulty using straw/cup_____ Spillage from mouth _____
Dislikes face washing _____ Hates brushing teeth _____
Bites/chew on non-food items _____

Food textures preferences (Please circle all that apply)
Crunchy Salty Cold Sour Hot Sweet Warm
Pureed Spicy Room Temp Semi-Solid Thick Liquid

ALLERGIES/Food
restrictions____