SPEECH LANGUAGE THERAPY SERVICES

Patient Intake Form

Please Print legibly

Patient Name: _____

Patient's DOB: _____ Patient's Gender: M F

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____

Parent/Guardian Printed Name: _____ DOB: _____

Cell Phone Number: _____

Email Address: _____

Parent/Guardian Printed Name: _____ DOB: _____

Cell Phone Number: _____

Email Address: _____

Primary Care Physician:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Physician Phone Number: _____ Fax: _____

Insurance Information:

Primary Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance Telephone Number: _____ Fax: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Policy Number: _____ Group Number: _____

Subscriber's Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Email address: _____ Relationship to Patient: _____

Subscriber's Employer: _____

Secondary Insurance Name:_____

Address:_____

City: _____State: _____ Zip Code:_____

Secondary Insurance Telephone Number:_____Fax:_____

Subscriber's Name:_____Subscriber's DOB:_____

Subscriber's Policy Number:_____Group Number:_____

Subscriber's Address (if different from patient):_____

City: _____State: _____ Zip Code:_____

Telephone Number:_____

Email address: _____Relationship to Patient: _____

Subscriber's Employer:_____

Tertiary Insurance Name:_____

Address:_____

City: _____State: _____ Zip Code:_____

Tertiary Insurance Telephone Number:_____Fax:_____

Subscriber's Name:_____Subscriber's DOB:_____

Subscriber's Policy Number:_____Group Number:_____

Subscriber's Address (if different from patient):_____

City: _____State: _____ Zip Code:_____

Telephone Number:_____

Email address: _____Relationship to Patient: _____

Subscriber's Employer:_____

I authorize speech therapy services to be performed for _____(patient) and agree to assign benefits for speech therapy services to Speech Language Therapy Services, LLC/ Nancy Lovering.

I have been provided a copy of Speech Language Therapy Services, LLC Notice of Privacy Practices. I understand that *on occasion* there may be an observer present in the clinic. I also understand that no personal information will be given out about my child, except that the observer may hear my child's first name during a treatment session.

Parent/Guardian Printed Name:_____Date:_____

Parent/Guardian Signature: _____Date:_____

Financial Agreement

Client Name: _____ **Date of Birth:** _____

Cancellation/Attendance policy

I understand that my child has a standing appointment for treatment services. His/her attendance is expected on the days for which he/she is enrolled.

I understand that there is a cancellation/no show charge of $50.00 if I fail to give the Speech Language Therapy Services, LLC staff at least a 24-hour notice that my child will be absent for any reason, excluding those times when an the onset of illness occurs after the 24 hour window. If my child will be absent on any given day, I will not be charged this fee if I give adequate notice. I understand that this fee cannot be billed to my insurance and I accept full responsibility for all cancellation charges and acknowledge that they are **due at my child's next appointment**.

Responsibility for Payment/Authorization to Bill Insurance

If insurance will not be filed, an individual payment plan will be required *before* the start of treatment. Speech Language Therapy Services, LLC has agreed to file insurance claims for my family. However, the balance is my responsibility regardless of what my insurance company pays (Medicaid excluded by federal law). ***Payment is due upon receipt of invoice.***

I authorize Speech Language Therapy Services, LLC and its associates to release any information required by my insurance company for the processing of all medical claims filed on my child's behalf.

I authorize my insurance company to pay benefits directly to Speech Language Therapy Services, LLC for claims filed on my child's behalf. If my insurance company pays a fee that I have already paid, I understand that I will be reimbursed by Speech Language Therapy Services, LLC.

I understand that Speech Language Therapy Services, LLC is a "preferred provider" for Alaska Medicaid and TriCare/TriWest insurances ***only***. Therefore, ***all*** charges not covered by my private insurance company are my own responsibility (Medicaid excluded by federal law).

I understand that I may be required to assist Speech Language Therapy Services, LLC in the processing of claims by my insurance company. If my insurance company has not processed a claim within 30 days of submission by the Speech Language Therapy Services, LLC, I may be requested to contact my insurance company to follow-up on the processing of the claim(s).

I understand that all accounts are to be paid upon receipt of invoice. Interest will be charged on outstanding balances exceeding 30 days, at a rate of 10% per 30 days, unless payment arrangements have previously been made. I also understand that if my account is turned over to a collection agency I will be responsible for all charges incurred in the collection process.

I acknowledge that I have read, understand and accept the above financial agreement.

_____	_____	_____
Parent/Guardian Signature	Parent/Guardian printed name	Date

Communications Policy

Phone and Face-to-Face
Speech Language Therapy Services, LLC will not give information about a patient to another person without the patient's (or patient representative) permission, unless permitted under state and federal law. The same principle applies to phone and text message communications. When Speech Language Therapy Services, LLC contacts patients for appointment reminders or other administrative matters, reasonable steps will be taken to avoid conveying protected health information (PHI) to any party other than the patient or the patient's representative.

Voicemail
Speech Language Therapy Services, LLC may leave messages regarding upcoming appointments or other administrative matters at the contact numbers on file. If the patient would prefer that voicemail not be left at the number(s) provided, please acknowledge so at the end of this communication policy.

Email Policy
At times Speech Language Therapy Services, LLC utilizes email to transmit patient-related communications. Whenever possible, Speech Language Therapy Services, LLC will utilize a secure method such as Direct Secure Messaging to transmit electronic communications. There is some risk that PHI contained in an email may be disclosed to, or intercepted by, unauthorized third parties. We will use the minimum necessary amount of PHI to respond to queries and will make every effort to keep patient PHI secure, in accordance with state and federal law. If the patient does not wish to receive correspondence via email, please acknowledge so at the end of this communication policy.

Ownership and User Privacy of Email
Use of electronic mail is a part of the business practices of Speech Language Therapy Services, LLC. All electronic communications originating from or received by Speech-Language Therapy Services and its associates are the property of Speech Language Therapy Services, LLC.

Confidentiality of Email
When email is used for communication of individually identifiable health information (PHI):

- The email address must be confirmed prior to sending any specific information about an individual's health condition.
- include the following as the footer to each message: **"This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error, please notify the system manager. This message contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this e-mail. Please notify the sender immediately by e-mail if you have received this e-mail by mistake and delete this e-mail from your system. If you are not the intended recipient you are notified that disclosing, copying, distributing or taking any action in reliance on the contents of this information is strictly prohibited."**;
- do not utilize group mailing or other distribution lists;
- email addresses should always be reviewed at least two times prior to sending the email, particularly if the email program utilizes auto-fill when entering a recipient address;
- any unnecessary information should be removed from the bottom of an email to ensure that the minimum necessary information is disclosed, if an email is being responded to;
- store incoming and outgoing messages in a manner consistent with their privileged or statutorily protected nature and segregated from non-privileged or non-statutorily protected material.

Retention of Electronic Mail

Often, email messages are non-vital and may be discarded routinely. However, some email may be considered a formal record and should be retained. For instance, all clinically relevant email messages, including the full text of a patient's query, as well as the reply, will be stored in the patient's medical record.

Fax Policy

At times Speech Language Therapy Services, LLC utilizes facsimile to transmit patient related communications. There is some risk that PHI contained in a fax may be disclosed to, or intercepted by, unauthorized third parties. We will use the minimum necessary amount of PHI to respond to queries and will make every effort to keep patient PHI secure, in accordance with state and federal law. If the patient does not wish to receive correspondence via fax, please acknowledge so at the end of this communication policy.

Receiving Faxes

When Speech Language Therapy Services, LLC receives a hard copy of a fax, the machine is in a private office. Received faxes will be removed from the fax machine promptly. When a fax is received electronically through a computer system, it will be password protected. Senders will be notified of any discrepancies.

I have read and acknowledge my understanding of the Communications Policy and have initialed my communication preferences above.

Signature	Printed Name	Date

Immunization and Vaccination Policy

Speech Language Therapy Services LLC has chosen to adopt a policy in accordance with The State of Alaska Child-Care and School Immunization Requirements (**4 AAC 06.055. Immunizations required**) which requires all children attending a state public school district or nonpublic school offering pre-elementary education to be immunized against:

- diphtheria, tetanus, polio, pertussis, measles, mumps, hepatitis A, hepatitis B, and rubella, except rubella is not required in children 12 years of age or older; and
- beginning July 1, 2009, varicella.

This policy will comply with all applicable laws and is also based on guidance from the Centers for Disease Control and Prevention and local health authorities, as applicable.

Childhood Immunizations

Immunization records are often provided by the referring physician however, if they are not, our staff may request the records from the referring physician or require the parents to provide them. The exceptions to this are:

- A valid Alaska state medical or religious exemption
  - A signed physician's statement is required if there are medical reasons a child cannot be vaccinated. Only the child's primary care physician (MD/DO), physician's assistant or advanced nurse practitioner is authorized to exempt children from immunizations.
- A 30-day waiver for those who are in the Child in Transition program or active-duty military dependents who have just been relocated to Anchorage.

On-site therapy sessions are only permitted if the child is in compliance with State of Alaska school immunization requirements. If a child is not of age for certain immunizations a medically verified record will be requested, showing the dates of all required immunizations received, and the remaining immunizations must be given as the child becomes age-appropriate.

If a parent discloses that their child has not completed the required immunization series appropriate for their age, the provider, in accordance with this policy, will discontinue any on-site services and teletherapy services will be made available immediately, so as not to disrupt the therapeutic needs of the child. In order to resume on-site services, the remaining immunizations must be received, or a signed statement from the child's primary care provider must be provided explaining the medical reasons the child cannot be vaccinated, or

documentation proving the child is in homeless transition, OCS custody, or recently relocated to Alaska as an active-duty military dependent.

COVID-19 Vaccination

The Centers for Disease Control and Prevention (CDC) have confirmed, based on scientific studies, that COVID-19 vaccines are effective at protecting individuals from severe illness and death. At this time, COVID-19 vaccinations have been approved by the Federal Drug Administration for all individuals 12 years of age and older. In order to limit the level of risk associated with close-contact exposure to COVID-19, we have chosen to follow the CDC social distancing and vaccination guidelines, and have implemented the following requirements:

- Children 12 years and older, who are eligible for the vaccine, will be required to receive the vaccine in order to attend on-site therapy services. For those families who chose not to vaccinate their child against COVID-19, teletherapy services will be made available to meet the therapeutic needs of their child.
- Parents vaccinated against COVID-19 will be permitted to attend their child's on-site therapy visits.
- Parents who choose not to be vaccinated against COVID-19 will not be permitted to attend their child's on-site therapy visits. The option to attend remotely through teletherapy will be made available to ensure you are included in the child's therapy in order to meet the therapeutic needs of their child.

As the ongoing COVID-19 pandemic continues to evolve changes to this policy will be made accordingly based on the updates made to the guidelines put in place by the CDC, as well as updates made with regard to vaccine availability by the FDA.

Acknowledgement

I accept the terms of the immunization and vaccination policy above. If it is found that I have not provided all the required documentation, or have falsified information, I acknowledge that services will be transitioned to the above mentioned teletherapy platform or terminated in accordance with this policy.

Printed Name: _____ Date: _____

Signature: _____

Release and Waiver for On-Site Services (COVID-19)

Patient Name: _____

DOB:_____

I voluntarily choose to have my child participate in the Speech Therapy service(s) provided by Speech Language Therapy Services LLC (the “Service Provider”). In exchange for receiving these services, I agree to the following:

1. Voluntary Participation. I acknowledge that I am giving permission for my child to participate in voluntarily, in-person services at the practice location of the Service Provider, and I recognize that participating in these on-site services may contain certain inherent risks due to the global COVID-19 situation. I am also aware that if at any time I become uncomfortable with continuing services on-site, that I may voluntarily decline to have my child participate. I understand that it is my right to discontinue participation and/or inform the Service Provider that I wish to discontinue on-site services at any time, as well as request an alternative mode of service delivery (if available).

2. Assumption of Risk of Exposure to COVID-19. By engaging in these services, I am aware that I agree to fully accept all known and unknown risks, including the potential risk of exposure to respiratory illnesses or other illnesses, diseases, or conditions, including but not limited to the coronavirus known as COVID-19. COVID-19 is primarily transmitted via exhaled respiratory droplets, most often through coughing, sneezing and breathing in proximity of another person. These droplets can travel up to more than six feet and are more commonly transmitted between persons rather than from equipment to persons. Although the Service Provider is making a good faith effort to comply with state laws, health mandates and executive orders by the municipality and governor, federal laws, local laws, and CDC guidelines regarding cleaning, disinfecting and practices which reduce the potential for exposure to COVID-19, I understand that I and my child may be exposed to COVID-19 or its symptoms through no fault of the Service Provider’s. Known coronavirus symptoms include fever, coughing, shortness of breath, pneumonia, kidney failure, and may include additional or other symptoms, stroke or even death (collectively referred to as "Symptoms"). I understand and agree to hold the Service Provider harmless and not liable for any real or perceived Symptoms of COVID-19 or any other disease, illness, or condition, nor for exacerbating any existing Symptoms of any illness, disease or condition, and I fully agree to

accept these and all other known and unknown risks of my child receiving services from the Service Provider.

3. Rules and Warnings. I agree to observe and obey all posted and announced rules and warnings, and further agree to follow any instructions or directions given by the Service Provider, or his/her employees and agents. I understand that if I am unwilling or unable to follow the rules and instructions given by the Service Provider, I may be asked to discontinue services or receive services through an alternative method, if available.

4. Disclosure of Compromising Medical Conditions. I agree to disclose to the Service Provider, in advance of the services being rendered, any known or suspected illness or ongoing medical condition(s) that may put myself, my child, or other members of my immediate household at risk of severe impact to our health if exposed to COVID-19. If I suspect that there is any issue or concern with receiving services on-site due to the disclosed illness or ongoing medical condition(s), I agree to inform the Service Provider so that accommodations can be made to provide alternative modes of service delivery (if available).

5. Seek Medical Advice. I agree to seek the advice of the necessary physician(s) for myself, my child, or other members of my immediate household regarding any questions or concerns I have about my child attending on-site services. If there are concerns, I understand that I am advised to follow-up with the above-mentioned physician(s) BEFORE receiving services, to determine whether myself, my child, or other family members in my immediate household are in proper health to receive these services on-site.

I have carefully read this Release and Waiver and by signing below I consent to it in its entirety.

Signature:_____
Printed Name:_____
Date: _____

No Show/Tardiness Policy

1. The date and time agreed upon is a standing appointment for your child's weekly speech therapy services and regular attendance is required.
2. Unless unavoidable, other appointments or obligations should not be scheduled during your child's designated appointment times.
3. We ask that you give the provider at least 24 hours' notice, so that they have adequate time to adjust their schedules accordingly, unless circumstances prevent you from doing so.
4. Failure to contact the provider with adequate lead time or not showing for an appointment will result in a $50 fee, due at your child's next visit.

Our office always holds a sizable waitlist, so this courtesy makes it possible for us to meet the growing need for services in our community as well as best serve our current patients.

Printed Name: _____ Date: _____

Signature: _____

Release of Information Authorization Form

Patient Name:	**SSN:**
AKA Name(s):	**DOB:**

People and entities I authorize to RECEIVE my personal health information (PHI)

Name of person(s) or entity(s):	Contact Information (address, phone, email)

Please list medical practitioner(s), spouse, caregiver(s), guardian(s), etc. you are authorizing to receive your PHI

People and entities I authorize to RELEASE my personal health information (PHI)

Name of person(s) or entity(s):	Contact Information (address, phone, email)

Please list medical practitioner(s), educational institutions, hospitals etc. you are authorizing to release your PHI

The purpose for this Release of Information Authorization:

I hereby authorize the use or disclosure of my health care and/or other information within my patient record to the entities stated above and that my records may contain sensitive information. I understand that this authorization is voluntary and that I may revoke this authorization at any time by signing the revocation section at the bottom of this form, or by notifying Speech Language Therapy Services, LLC in writing. I acknowledge that revoking this authorization will not affect actions taken on this authorization prior to the date the revocation was received. I understand that Speech Language Therapy Services, LLC will not condition my treatment, payment, or eligibility for services based on whether I provide this authorization.

I understand that if the person(s) or entities I authorize to receive my protected health information are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipients of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

Signature of Patient or Personal Representative: **Date:** **(Or witness if signature is by mark)**
Printed name of Personal Representative (or witness description of Personal Representative's Authority):
Complete when/if revoked **This authorization was revoked on: _____ (date)** **Signature of Patient or Personal Representative:**

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL