tandem
SPEECH THERAPY

New Patient Packet

Part I - Intake

Part II - Administrative Policies

HIPPA Privacy Policy

Authorization to Exchange, Obtain or Release Information

Part I - Intake

Demographics

Child's Name:

Date of Birth:

Physician's Name:

Physician's Phone:

Referral Source:

Parent/Caregiver Names:

Parent/Caregiver Phone:

Parent/Caregiver Email:

Speech/Language Concerns

Please describe any communication difficulties:

What are your goals for speech therapy?

When did the communication difficulties begin?

Has your child had a recent hearing assessment?

Has your child ever had a speech/language evaluation?

Where was the evaluation conducted? What were the findings?

Has your child ever receive speech/language therapy?

Are there any other concerns about your child's development?

Does your child become agitated or frustrated because of lack of communication?

Social Environment

Who does the child live with? (Please list ages of siblings in the home):

Child's languages and percentages of time used:

Name of school/daycare and current grade/level:

How is your child performing academically?

How does your child get along with their peers? Siblings?

What other activities does your child participate in? Favorite toys/games? Interests?

Birth/Developmental History

Was your child born full-term?

Was the pregnancy free of complications?

Provide any relevant information regarding your pregnancy or child's birth (premature, NICU stay, complications, reasons, etc.):

How old was your child when they babbled?

How old was your child when he/she said first words?

How old was your child when he/she combined two words?

How old was your child when he/she spoke in short sentences?:

Does your child have difficulty:

- ▢ understanding you?
- ▢ following simple directions?
- ▢ making wants/needs known using words?
- ▢ responding to yes/no questions?
- ▢ communicating with gestures?
- ▢ being understood by others?

Medical History

Describe in detail any medical issues you feel are pertinent:

List any known allergies:

List any medications your child takes regularly:

List any other physicians or therapists involved in your child's care:

Has your child had recurring ear infections which resulted in tubes?

Provide any other information you which to share with Emily:

Part II - Administrative Policies

Child's Name:

Date of Birth:

Person Completing Form:

Relationship to Child:

Consent for Services

▢ I authorize Tandem Speech Therapy, PLLC to render appropriate evaluation and therapy services to the client named above in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Tandem Speech Therapy, PLLC in writing. In addition, Tandem Speech Therapy, PLLC may terminate services by notifying me in writing.

▢ I do not give my consent or am withdrawing my consent regarding Tandem Speech Therapy, PLLC rendering evaluation and therapy services to the client named above.

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Tandem Speech Therapy, PLLC is required by law to keep your health information and records safe. This information may include: Notes from your doctor, teacher or other healthcare provider; Medical history; Test results; Treatment notes. We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. Please read and check of all boxes to acknowledge understanding:

▢ I acknowledge that I have received a copy [available upon request] of Tandem Speech Therapy, PLLC's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

▢ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

▢ I understand Tandem Speech Therapy, PLLC cannot disclose my health information other than as specified in the notice.

▢ I understand that Tandem Speech Therapy, PLLC reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

Authorization to Exchange, Obtain or Release Information

For the reasons identified in this form, I hereby grant Tandem Speech Therapy, PLLC permission to communicate (exchange, obtain, or release) my medical information with the following person or agency:
Name of Person or Agency:

Person/Agency Contact Information:

Information to Be Released (check all that apply):
▢ Medical History
▢ Therapy Evaluation
▢ Treatment Notes
▢ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of (check all that apply)
▢ Coordinating care with other professionals
▢ Providing continuity of services
▢ Updating therapeutic progress

▢ I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.
▢ I understand that this authorization will remain valid until written revocation of this authorization is presented.

Payment Policy

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Tandem Speech Therapy, PLLC for payment of services provided. By signing this policy/document, you are agreeing to pay for services provided to you or your family member. As a client of Tandem

Please read the following information carefully:
All therapy fees, including session fees, are due at the time of service.
We accept the following payment methods at this time: credit card via the TheraNest client portal, check, or cash. Checks should be made payable to Tandem Speech Therapy, PLLC.
We will provide you with an invoice outlining the services rendered and the amount charged.

Please read and check of all boxes to acknowledge understanding:

▢ I understand that I am responsible for all costs associated with the services provided by Tandem Speech Therapy, PLLC. I also understand that Tandem Speech Therapy, PLLC will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

▢ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

▢ I understand that all returned checks will be subject to a $30 returned check fee. Charges incurred and not paid after 14 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

▢ I understand that I am responsible for all legal and collection fees, which Tandem Speech Therapy, PLLC may incur if payment is not made in accordance with the terms and conditions herein.

▢ I, understand that all cancellations require 24 hours' notice and that there will be a $40 charge for any cancellations made less than 24 hours. This charge is my sole responsibility and will not be covered for reimbursement by a third-party source.

Attendance/Cancellation Policy

Attendance and participation in therapy, along with complete compliance with any associated home programs are essential for therapeutic success.

While Tandem Speech Therapy, PLLC understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows". Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, or any other event.

All cancellations must be submitted 24 hours prior to your scheduled appointment.

A fee of $40 may be assessed if the following occurs. This fee will be billed directly to the client, as medical insurance does not provide reimbursement for missed sessions.
If cancellations are made less than the required 24 hours.
If the client fails to be at home for a scheduled appointment.

If you miss/reschedule/are late for 3 scheduled appointments, the office reserves the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

Acknowledgement

I hereby acknowledge and agree that I read all of the above information found in part II.

Signature: _____ Date: _____

APPENDIX

HIPPA Privacy Policy

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.

Protection of Health Information: Your health information is kept private according to the federal privacy regulations under the Health Insurance Portability and Accountability Act of 1966 (HIPAA) and you are provided with notices of the legal duties and privacy practices within this practice. Your protected health information is information that relates to your past, present, or future health care. This includes your medication history, diagnostic evaluations, and therapeutic services.

Uses and Disclosures of Your Protected Health Information: Disclosure of your health information may occur for health care operations. Examples of operations in which protected health information disclosures may occur include insurance and billing, management, financial or quality assurance audits, law enforcement purposes, education, referring to other services, and receiving information from other professionals that may have treated you in the past. Your protected health information may be used for treatment purposes inducing provisions, coordination or management of services. Some other examples of disclosures include the following:
- Appointment reminders via voicemail or email
- Medical records may need to be transferred to another location

Your Rights Regarding Your Health Information: You have the right to review your health information which might include intake information, evaluation, session notes, goals, and progress notes. For all other purposes beyond those listed above, your written authorization will be required to use, disclose, or restrict your protected health information. Your authorization can be revoked at any time except to the extent that we have relied on the authorization. Revocations must be in writing. You may also initiate the process for your information to be sent to someone else through the use of an authorization form or written request. To request further restriction or disclosure, you must submit a written request that explains what information you want restricted, how you want the information restricted, and from whom you want the restriction to apply.

Notice of Privacy Practices: By law, this practice abides by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time. The revised notice will be available on request from our office.

Complaints: If you believe that your privacy rights have been violated, you may submit a complaint to this practice or to the U. S. Department of Health and Human Services. To file a complaint with the practice, submit the complaint in writing. You will not be penalized or retaliated against for filing a complaint and your identity will be kept confidential.

Authorization to Exchange, Obtain or Release Information

Child's Name:

Date of Birth:

For the reasons identified in this form, I hereby grant Tandem Speech Therapy, PLLC permission to communicate (exchange, obtain, or release) my medical information with the following person or agency:

Name of Person or Agency:

Person/Agency Contact Information:

Information to Be Released (mark all that apply)

- ❏ Medical Records
- ❏ Therapy Evaluation
- ❏ Treatment Notes
- ❏ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of (mark all that apply)

- ❏ Coordinating care with other professionals
- ❏ Providing continuity of services
- ❏ Updating therapeutic progress

By signing below:

- ❏ I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.
- ❏ I understand that this authorization will remain valid until written revocation of this authorization is presented.

Signature _____ Date _____