EXPRESSIVE SPEECH & FEEDING

INTAKE FORMS

_____ _____
Print Name of Client Date

_____ _____
Print Name Person Completing Forms Relationship to Client

HIPAA POLICY - 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) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. 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. 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.

- **Treatment** means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **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 be an internal quality assessment review.
- We may create and distribute de-identified health information by removing all references to individually identifiable information.
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- 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 the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, 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 reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Expressive Speech and Feeding, LLC 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
- Insurance information

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.

- I acknowledge that I have received a copy of Expressive Speech and Feeding, LLC'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 Expressive Speech and Feeding, LLC cannot disclose my health information other than as specified in the notice.
- I understand that Expressive Speech and Feeding, LLC 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.

Signature of Client or Legal Representative

Please Note: It is your right to refuse to sign this Acknowledgement. Please email janine@expressivespeechandfeeding.com if you have any questions or concerns.

EXPRESSIVE SPEECH & FEEDING

Attendance / Cancellation Policy

Attendance and participation in therapy along with compliance with any associated home programs, are essential for therapeutic success. While Expressive Speech and Feeding, LLC understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows". **Please read and sign below to acknowledge understanding and agreement.**

- **All cancellations must be submitted at least 24 hours prior to your scheduled appointment.**
- A fee of the full session rate may be assessed if a therapy session is canceled for any reason other than illness with less than 24-hour notice. This includes (but is not limited to) last-minute cancellations for vacation, doctors' appointments, school events, family work obligations, etc. If the client does not show up for a scheduled appointment and does not communicate with the therapist or staff to cancel, you will be assessed a session fee.
- If you reschedule / are late for 2 scheduled appointments within 30 days, the office will reserve 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 canceled. If you will be late for an appointment, please notify your therapist as soon as possible. There is a 15-minute grace period for late arrivals. If a session is unable to start within 15 minutes of the scheduled start time, it will be canceled, and a cancellation fee applied.
- If you fail to appear for an appointment (no show) without providing the appropriate advance notification for 2 or more appointments within 2 weeks, the office will reserve the right to cancel all pending appointments and to no longer offer services to you as a client.
- If a child or therapist has had a fever of 99.9 degrees (or above) or has vomited within 24 hours of the scheduled appointment, the appointment will be canceled. If your child is ill, we ask that notify your therapist as soon as possible to cancel the session. As a general rule, if your child is too sick to attend daycare or school, then they are too sick for therapy. There will be no cancellation fee for sessions canceled due to illness. Expressive Speech and Feeding, LLC reserves the right to request documentation of illness.
- It is expected that missed sessions, whether by the client or the therapist, will be made up within 30 days.
- I understand that terminating services with less than 2-weeks' notice may incur cancellation fees.
- I understand the attendance / cancellation policy and the risks of not adhering to it.

_____

Signature of Client or Legal Representative

EXPRESSIVE SPEECH & FEEDING

Payment Policy & Fee Schedule

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 Expressive Speech and Feeding, LLC for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client Expressive Speech and Feeding, LLC you must carefully review and sign our payment policy.

Monthly invoices are sent on the last business day of the month. Monthly invoices will be automatically charged to the credit card on file. If we are unable to charge the credit card on file within 7 days of the invoice date, a 10% late fee will be assessed and a second invoice will be issued. An additional 5% late fee will be added for every additional 7 days an invoice is overdue. If invoices are unpaid after 30 days (from the date of posting of the invoice), services will be suspended and accounts turned over to a collections agency. Please note that we process credit card charges once per month to minimize fees. Should you require multiple charges within the same month, you will be responsible for covering additional credit card fees beyond the initial charge (approximately 3.3% + 30 cents).

Speech-Language evaluation and report	$300
Feeding evaluation and report	$300
Speech **and** Feeding evaluation and report	$550
Infant Feeding Evaluation and report (for babies exclusively bottle / breastfed)	$225
Individual speech-language or feeding therapy	$145 / hour

We accept only credit card payment via Square. We require all clients to keep a current credit or debit card and authorization on file. We will provide you with an invoice and superbill outlining services rendered and amount charged.

Please read and sign below to acknowledge understanding and agreement:

- I understand that health insurance policies and reimbursement are between myself and my health insurance company, that all services rendered by Expressive Speech and Feeding, LLC for the benefit of the above referenced individual are charged directly to me, and I am personally responsible for payment in full to Expressive Speech and Feeding, LLC. I also understand Expressive Speech and Feeding, LLC won't become involved in disputes between me and a third-party source regarding uncovered charges or reasons for denial.
- I understand if fees are not paid in full, treatment sessions may be canceled until payment is received.
- I understand that I am responsible for all legal and collection fees, which Expressive Speech and Feeding, LLC may incur if payment is not made in accordance with the terms and conditions herein.
- I understand the payment policy and the risks of not adhering to it.

Signature of Client or Legal Representative

Payment Policy & Fee Schedule (Updated 2/12/2024)

EXPRESSIVE SPEECH & FEEDING

INFORMED CONSENT FOR IN-PERSON SERVICES

Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Risks of Opting for In-Person Services
You understand that by attending sessions in-person, you are assuming the risk of exposure to the coronavirus (or other public health risk). **By signing this document, you agree not to hold accountable Expressive Speech and Feeding, LLC for any injury to yourself or family (including but not limited to personal injury, disability, illness, and/or death) that may be experienced in connection with your attendance at Expressive Speech and Feeding in-person services.**

If You or I Are Sick
You understand that I am committed to keeping you, me, and all of our families safe and healthy. If you show up for an appointment and I believe that you have a fever or other illness symptoms, I will end the session immediately. We can follow up with services by telehealth as appropriate.

Please read and sign below to acknowledge that you understand and agree to these actions:

- You will only keep your in-person appointment if you are COVID-19 symptom and other illness free.
- The client will wash hands or use alcohol-based hand sanitizer upon arrival.
- Masking is no longer required; however, I will wear a mask upon request for any family that wishes that I do so.
- If a resident of your home tests positive for COVID-19, you will immediately let me know and we will then resume treatment via telepractice or pause service until tests are negative.
- The facility cannot guarantee an allergen-free environment.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____
Signature of Client or Legal Representative

Informed Consent (Updated 2/12/2024)

EXPRESSIVE SPEECH & FEEDING

Authorization for Credit Card Use

By signing this form you give Expressive Speech and Feeding, LLC permission to debit your account for the amount indicated on or after the indicated date. This is permission for current and future services as outlined in this agreement and does not provide authorization for unrelated debits or credits to your account.

Name on Card: _____ Email Address: _____

Billing Address : _____
(including zip)
_____

Credit Card Type:

☐ Visa ☐ Discover
☐ Mastercard ☐ American Express
☐ FSA ☐ Other _____

Credit Card Number: _____

Expiration Date: _____ Card Identification Number: _____ (3 or 4 digits on back of card)

- I authorize Expressive Speech and Feeding, LLC to charge fees rendered for services to the credit card provided herein.
- I understand that the provided credit card will be charged for services rendered at the end of the month and that I will receive an electronic invoice as a receipt of payment. Printed invoices available upon request.

Cardholder, please sign and date:

Print Name: _____ Signature: _____ Date: _____

Credit Card Authorization

I authorize Expressive Speech and Feeding, LLC to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for therapy services, for the amount invoiced by the practice, and is valid for ongoing monthly and weekly services. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

EXPRESSIVE SPEECH & FEEDING

Consent and Release of Photographs / Videos

- I give consent to Expressive Speech and Feeding, LLC to photograph and/or video record my child / myself in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, and demonstration of progression of his/her skills.
- I authorize Expressive Speech and Feeding, LLC to use pictures my child, the client, for promotional purposes (ex. brochures, website, etc.)
- I acknowledge that I will receive no financial compensation for providing consent since my participation with Expressive Speech and Feeding, LLC in providing my consent and release is voluntary.
- I hereby release Expressive Speech and Feeding, LLC, their contractors, their employees and/or any third parties involved in the creation or publication of Expressive Speech and Feeding, LLC from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.
- I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent and release.

_____

Signature of Client or Legal Representative

_____

Client

_____

Date