Speech Avenues Therapy Co.

107 Longwood Avenue

Rockledge, FL 32955

321-338-2419 office

321-3014278 fax

**Attendance I Cancellation Policy**

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

While Speech Avenues Therapy Co. 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, obligations for work or family, or any other event.

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

A fee of $50.00 may be assessed if the following occurs. This fee will be billed directly to the client and not their health insurance company, as medical insurance does not provide coverage for missed sessions.

If cancellations are made less than the required 24 hours.

If the client fails to show up for a scheduled appointment.

If you cancel without rescheduling for 4 scheduled appointments within (a plan of care), 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 cancelled.

If you fail to appear for an appointment (no show) without providing the appropriate 24-hour advance notification for 3 consecutive or more appointments within (a plan of care) the office will reserve the right to cancel all pending appointments and to no longer offer services to you as a client.

I understand the attendance / cancellation policy and the risks of not adhering to it.

 

Print Name of Client Date

 

Signature of Client or Legal Representative Relationship to Client



# 107 Longwood Avenue

# Rockledge, FL 32955

# P#321-338-2419 / F# 321-301-4278

# **General Acknowledgement of Form**

I hereby acknowledge and agree that I had read all the forms and documents provided to me in connection with evaluation and treatment provided by Speech Avenues Therapy Co. and/or their employees.

I understand the meaning and intent of the provided forms and agree to ail content included.

I have been given an opportunity to ask questions about the provided forms and all questions I have asked have been answered to my satisfaction by Speech Avenues Therapy Co.

 

Print Name of Client Date

 

Signature of Participant or Legal Representative Relationship to Client



107 Longwood Avenue Rockledge, FL 32955

P:321-338-2419/ F:321-301-4278

**HIPAA - Your Privacy Rights**

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.

Effective date: (date signed)

Speech Avenues Therapy Co. is required by law to keep your health information safe. This information may include:

* notes from your doctor, teacher, or other health care provider
* your medical history
* your test results
* treatment notes
* insurance information

A government rule, called the Health Insurance Portability and Accountability Act, or HIPAA, requires that you get a copy of this privacy notice. We will ask you to sign a paper saying that you have been given this notice. Read and refer to this notice at any time to see how your health information can be used and who can see it.

How Your Health Information May Be Used or Shared

We may use or share your health information without your permission for the following reasons:

* Treatment. We may share information with doctors and other health care providers who care tor you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.
* Payment. We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for services. This may include sharing important medical information. We may share information to:
* get the insurance company's permission to start treatment
* get permission for more treatment o get paid for the treatment you receive
* Health Care Operations. We may use and share your health information to run the clinic and be sure that all patients receive good care. For example, we may use your health information to:
* see how well our services are working
* see how well our staff is doing o see how we compare to other clinics
* make our services better o help others study health care services

Your Health Information May Also Be Used or Shared Without Your Permission for:

* Abuse and Neglect, we may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.

**Appointment Reminders**.

We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by e-mail, or by phone

call or voicemail message. If you do not wish to get reminders, please tell your speech-language pathologist.

**As Required by Law.**

* We will share your information when we are told to do so by federal, state, or local law. We will also share information if we are asked by the police or courts.

**Government Functions.**

* Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
* Information About a Person Who Has Died. We may share information with the coroner, medical examiner, or a funeral director, as needed.

**Marketing.**

* We may use your information to let you know of other services that might be of interest to you.
* Public Health Risks.
* We may report information to public health agencies as required by law. This may be done to help prevent
* disease, injury, or disability.
* It may also be done to report medical device safety issues to the Food and Drug Administration and to
* report diseases and infections.

**Regulatory Oversight.**

* We may use or share your information with agencies overseeing health care. This may include sharing information for audits, licensure, and inspections.

**Research.**

* We may share your health information with researchers to be included in their research project. Information will be shared only for projects that have been through a special approval process. These projects have rules to protect your privacy, too.

**Threats to Health and Safety**.

* Your health information may be shared if we believe that it will prevent a threat to your health and safety or the health and safety of others.

**Worker's Compensation.**

* We will share your information with Worker's Compensation if your case is being considered as a work-related injury or illness.

**When Your Permission Is Needed to Use or Share Your Health Information**

* You must give us permission to use or share your health information for any situation that is not listed in this notice.
* You will be asked to sign a form, called an authorization, to allow us to use or share your information.
* You are allowed to take back this authorization, called revoking authorization, at any time.
* We will not be able to get back the information that we shared with your permission.

**Your Privacy Rights**

You have the right to:

* Ask us not to share your information. You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
* Ask us to contact you privately. You can ask us to contact you only in a certain way or at a certain place. For example, you may want us to call you but not to e-mail you. Or you may want us to call you at work and not at home. You must ask us in writing. We will do all we can to do what you ask.
* Look at and copy your health information. You have the right to see your health information and to get a copy of that information. You have a right to see treatment, medical, and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
* Ask for changes to your health information. You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
* Get a report of how and when your information was used or shared. You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this:
* You need to ask us in writing.
* You must tell us the dates you are asking about and if you want a paper or electronic copy.

You may get information going back 6 years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.

**Get a paper copy of this privacy notice.**

You can get a paper copy of this notice at any time. You can get a copy even if you have already signed the form saying you have seen this notice.

**File complaints**

You can file a complaint with us or with the government if you think that o your information was used or shared in a way that is not allowed o you were not allowed to look at or copy your information o any of your rights were denied

**Who Is Covered by This Notice?**

The people who must follow the rules in this notice are:

* All speech-language pathologists working at Speech Pathways of Brevard o anyone who is allowed to add health information to your file, including students and other staff
* Any volunteers who may help you while you are in this clinic

**Changes to the Information in This Notice**

We may change this notice at any time. Changes may apply to information we already have in your file and to any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

**Complaints**

You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. To find out more about filing complaints, go to www.hhs.qov/ocr/prjvacy/hipaa/complajnts/index.html. All complaints must be in writing. You will not get in trouble for filing a complaint.

**Contacts**

If you have any questions about this notice or your privacy rights, please ask your speech-language pathologist or contact Gail Walter at 321-626-7777 or 321-338-2419. You can also email us at: admin@speechavenues.com



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## **Acknowledgement That You Have Received Our HIPAA Privacy Notice**

Speech Avenues Therapy Co. 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 o 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 Speech Avenues Therapy Co'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 Speech Avenues Therapy Co. cannot disclose my health information other than as specified in the notice.

I understand that Speech Avenues Therapy Co. 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.

 

Print Name of Client Date

 

Signature of Client or Legal Representative Relationship to Client



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# **Consent for Services**

I authorize Speech Avenues Therapy Co. to render appropriate evaluation and therapy services to the client named below 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 Speech Avenues Therapy Co. in writing.

In addition, Speech Avenues Therapy Co. may terminate services by notifying me in writing.

I do not give my consent or am withdrawing my consent regarding Speech Avenues Therapy Co. rendering evaluation and therapy services to the client named below.



Print Name of Client Clients Date of Birth Today’s Date



Signature of Client or Legal Representative Relationship to Client



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## **Payment Policy & Fee Schedule**

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 Speech Avenues Therapy Co. 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 of Speech Pathways Therapy Co. you are required to carefully review and sign our payment policy.

**Fee Schedule**

(Effective 01/01/2019)

Copy given upon request

**Please read the following information carefully:**

All therapy fees (including session fees and/or co-pays, if applicable) are due:

* At the time of service
* Payment arrangements previously discussed

We accept the following payment methods currently check, cash, debit and credit card,

Checks should be made payable to:

Speech Avenues Therapy Company

We will provide you with an invoice outlining the services rendered and the amount charged.

Name of Client: Date of Birth: 

**Please read and check all boxes to acknowledge understanding and the sign below:**

* I understand that I am responsible for all costs / fees that any third-party payer (ex. commercial insurance company, private school, etc.) does not cover. If a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Speech Avenues Therapy Co. will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial. I understand if I have received Medicaid insurance that I will not be billed for services.
* 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 $25.00 returned check fee. Charges incurred 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 Speech Avenues Therapy Co. may incur if payment is not made in accordance with the terms and conditions herein.
* I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within a week after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Clients who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

I,(client / guardian name) understand the payment policy and the risks of not adhering to it.



Print Name of Client Date of Birth



Signature of Client, Guardian, or Responsible Party Relationship to Client



Private Practitioner / Witness Date

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## 107 Longwood Avenue Rockledge, FL 32955

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**Consent for Observation**

I,  (client or parent/guardian name) hereby grant Speech Avenues Therapy Co. and their consultants, contractors, or employees to observe  in the following setting(s):

(Client’s name)

Name of Location

Day Care 

School 

Work 

Other: 

For the purpose of: 

I understand that during this observation, Speech Avenues Therapy Co., their consultants, their contractors, or their employees may speak to providers, clinicians, teachers, employers, etc. about the client and I thereby grant permission for such discussions.

I am the client, parent or legal guardian of the person named below and have the legal authority to provide consent for observation.

 

Print Name of Client Date

 

Signature of Client or Legal Representative Relationship to Client



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**Video Release Form**

l,hereby grant permission to Speech Avenues Therapy Co., the rights of my image, in video or still, and the likeness and sound of my voice as recorded on audio or video, I understand there is no payment or any other compensation. I understand that the image may be edited, copied, exhibited, published, or distributed.

I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.



Print Name of Client Date of Birth



Signature of Client, Guardian, or Responsible Party Relationship to Client



Private Practitioner / Witness Date

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Description automatically generated

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#### **Authorization for Release of Information**

I give Speech Avenues Therapy Co. permission to use, share or request my health information with:



The information that will be used or shared includes (check all that apply):

* My medical records
* My treatment records (progress notes, daily records)
* My speech, language, or swallowing test results
* Other:

This information is being used or shared for:



This authorization will expire after 1 year from the date signed unless you specify a different date below:



Or after the following event happens:



I understand that:

* I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
* I am allowed to see or request a copy of the health information that will be used, shared, or requested at .15 cents per page.
* I can take back this authorization at any time. I need to write to Gail Walter at 1237 Florida Ave S. Rockledge, FL 32955 to do this.
* Any information that was used or shared before I took back the authorization cannot be returned.
* The person or organization that gets my health information because of this authorization, may have the right to share it with others without my permission.



Clients Name Date signed



Parent/Guardian signature Relationship to Client

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## 107 Longwood Avenue Rockledge, FL 32955

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**Authorization to Exchange, Obtain or Release Information**

Client Name:  Date of Birth: 

I,  (client or family member), hereby grant Speech Avenues Therapy Co. permission to

communicate with the following person or agency:

Name: Contact Address/Phone #: Relationship to client





**Information to Be Released:**

Medical History

Therapy Evaluation

SLP D OT O PT O Other: 

Treatment Notes

SLP O OT O PT O Other:

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

Other: 

I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.

I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.

 

Print Name of Client Date

 

Signature of Parent/Guardian Relationship to client