Therapeutic Speech and Language Services, Inc.

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Registration Form for Therapy Services

Today's Date: _____ Child's Date of Birth: _____ Male_____Female _____

Child's Full Name: _____

Parent/Guardian'sName:_____

Address: _____

Home Phone #: _____Cell Phone #: _____Work Phone #_____

Email Address: _____

Pediatrician's Name: _____Pediatrician's Phone:_____

Day Care Name:_____ Day Care Phone:_____

Day Care Address: _____Days at Day Care (circle): M T W TH F S Sun

Day Care drop off time:_____ Day Care pick up time:_____

Consent to treatment and authorization to release information and assignment of benefits

I hereby authorize the staff of Therapeutic Speech and Language Services, Inc./ Sarah Hay, PhD CCC-SLP to perform such evaluative and therapeutic procedures as they may deem necessary or advisable from time to time. I further authorize Therapeutic Speech and Language Services, Inc./ Sarah Hay, PhD CCC-SLP to release any appropriate evaluative and/or therapeutic treatment information to the center's therapeutic and consultative team, and/or third party payers (Medicaid, Peach State, and Amerigroup or private insurance companies when needed for reimbursement purposes). I give my permission for my child's private information to be emailed through a non-secure email, and for therapists to text sensitive information about my child through mobile devices. I agree to be personally responsible for any charges to my account.

_____ _____ _____ _____

Print Name Signature Relationship to Client Date

Insurance Information

We only take the following insurances: (Medicaid, Peach State, Amerigroup, CareSource, and Ambetter)

Primary Insurance Company:_____Member ID/Medicaid #: _____

Policy Number: _____ Deductible: _____ CO-Payment:_____

Secondary Insurance Company (if applicable):_____

Assignment of Insurance Benefits and Release Information

Policy Holder CHECK ONE of the following below and sign below:

_____ I hereby authorize and direct my insurance company to pay directly to Therapeutic Speech and Language Service, Inc. and/or Sarah Hay PhD CCC-SLP any insurance benefit otherwise payable to me. I further authorize and direct Therapeutic Speech and Language Services, Inc and/or Sarah Hay PhD CCC-SLP to release all information with respect to me or any of my dependents that may have bearing on the benefits payable under the above stated insurance plan providing benefits or services. I understand that I am financially responsible to Therapeutic Speech and Language Services, Inc and/or Sarah Hay PhD CCC-SLP for any charges not paid by my insurance.

_____ I elect not to assign benefits to Therapeutic Speech and Language Services, Inc/Sarah Hay PhD CCC-SLP at this time. I understand that I may request to do so at a later date. I further understand that I am directly responsible to Therapeutic Speech and Language Services, Inc. and/or Sarah Hay PhD CCC-SLP for the full charge of services.

_____ _____ _____ _____ _____

Print Name Signature Relationship to Client Date

Parental concerns: (following directions, grades held back, reading difficulties, trouble understanding child, trouble with attention, holding pencil, etc): _____

_____

Please list any significant medical or developmental information (surgeries, delivery complications, diagnoses, head injuries, hospitalizations, etc):

_____

_____

Does your child have a current IEP or IFSP: yes or no

Has your child had speech or occupational therapy previously? If so, what company, when and for how long?_____

_____

Ages for: 1st words: _____ two-word combinations:_____ three-word combinations:_____

crawling:_____First steps:_____ potty trained:_____

THERAPEUTIC SPEECH AND LANGUAGE SERVICES, INC.
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 (HIPA) requires all health care records and other individually identifiable health information (projected health information: PHI) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. Without specific written authorization, we are permitted to

- use and disclose your health care records for the purpose of treatment, payment and health care operations.
- Treatment means providing, coordinating, or managing health care and related services by one or more health care provides. Examples of treatment would include therapy, evaluations, and parent education.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization. An example of this would be billing your insurance plan for your services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement of activities, auditing functions, cost-management analysis, and customer service.

In addition, your PHI may be used to remind you of an appointment (by phone, email, or mail) or provide you with information about treatment options and other health-related services including release of information to friends and family members that are involved in your child's care. We will use and disclose your PHI when we are required to do so by federal, state and local law. We may disclose your PHI 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 you PHI if requested by a law enforcement official for any circumstance requested by law. 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 abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your PHI, 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 used and disclosures of PHI, 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 communication of PHI from us by alternative means or alternative locations.
- The right to access, inspect and copy your PHI, amend your PHI.
- The right to receive an accounting of disclosure of PHI 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 PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. 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 out Notice of Privacy Practice and to make the new notice provisions effective for all PHI that we maintain. You have the right to file a formal complaint with us please call: 404-625-1421, in the event you feel your privacy rights have been violated. Or, you may call the U.S. Department of Health and Human Services at: (877)696-6775. We will not retaliate if you file a complaint.

Sign:_____Date_____

TELEHEALTH CONSENT FORM

The American Speech and Hearing Association (ASHA) defines telepractice (the act of providing Telehealth services) as "the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation." This means that we are able to provide speech therapy services through digital meetings similar to the popular communication system “Skype”. While we do not specifically utilize skype for the provision of services, the method of delivery would be similar in nature. The therapist and the child would join a computer based session at the designated therapy time, and would work on the same materials as in the office. We term this “teletherapy.”

It is important to know that this service delivery model is supported through American Speech-Language- Hearing Association (ASHA), and is payable by most insurance carriers per the Telehealth Enhancement Act of 2013- H.R.3306, 113th Congress. This mode of service delivery, when implemented correctly, is noted to have equal outcomes to face-to-face interventions.

I _____hereby consent to engage in teletherapy with a licensed Speech-Language Pathologist and/or Occupational Therapist working with Therapeutic Speech and Language Services, Inc (TSLS) and/or Hay Therapy (HT). I understand that “teletherapy” includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical information, both orally and visually.

I understand the following with respect to teletherapy:
I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of TSLS/HT, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

I understand that I am responsible for (1) providing and paying for the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

Teletherapy has been determined as an appropriate service delivery model for this patient. Teletherapy will only be used if determined to be at least as effective as in-person treatment. If teletherapy is not deemed as effective, you will be notified and referred back to in-person treatment. In order to participate in teletherapy, the patient must first participate in an in-person evaluation. For certain individuals, we ask that an adult facilitator be present in the room for assisting with technical difficulties, or keeping a child on task.

Teletherapy may be used as the primary means of service delivery, if deemed necessary, or may be used in combination with in-person services. I have read, understand and agree to the information provided above.

_____ _____ _____

Patient Name (Printed) Patient Guardian Signature Date & Time