Clearly Speaking

87 Lafayette Road Unit #3 • Hampton Falls, NH 03844
603.926.3277 • www.clearlyspeakingNH.com

Our Promise of Privacy to You

Clearly Speaking is fully committed to compliance with HIPPA guidelines:

- We provide appropriate security measures for all our patient's medical records.
- Protect the privacy of all our patient's medical records.
- Provide our parents/guardians with proper access to their child's records.
- Appropriately maintain our patient information and billing processes in compliance with the national HIPPA standards.
- Disclose copies of records to other entities for the sole purpose of treatment, only at the written request of the parent or legal guardian.
- Take all precautions necessary in protecting the right to privacy for our clients.

An unabridged version of Clearly Speaking Notice of Privacy Practices is available for your review. You have the right to review this notice prior to signing this consent. A copy of this notice may be obtained at any time.

I have been provided an opportunity to review the Notice of Privacy Practices.

Parent/Guardian's Signature:_____

Date:_____

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Case History

Child's name: _____

Date of birth: _____

Pediatrician: _____

Sibling(s) and age(s):

What language(s) does the child speak at home? _____

Describe the current speech and/or language problem:

Is the child aware of the problem? _____

Is he/she motivated to improve? _____

Has your child received speech and/or language services prior to now?

Is there a history of speech/language or hearing problems in your family?

Birth history:

Was the child born prematurely? _____

Were there any complications at birth? _____

Medical history:

Please mark any condition that your child is currently experiencing or has experienced.

Asthma ____

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Seizures ____

Tonsillitis ____

Allergies ____

Ear Infections ___ How many? _____

Has your child had his/her hearing tested? _____

When?

Has your child had a tonsillectomy or adenoidectomy? _____

When?

Is your child currently taking any medication?

Developmental history:

At what age did your child do the following?

Sit up unassisted _____

Crawl _____

Walk _____

Babble_____

Speak first word _____

Does your child have any problems related to feeding?

Does your child use a sippy cup? If yes, how long?

Does your child suck his/her thumb? If yes, how long?

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Does your child use a pacifier? If yes, how long?

Please summarize any additional information that you think would help us in working with your child.

How would you rate your concern regarding your child's current speech challenges, 1-5?

What is your goal in regards to this evaluation and treatment?

Thank you for taking the time to fill out this information. We look forward to working with you and your child.

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Request for Exchange of Information

I give permission to exchange information (medical records, school records, progress notes, evaluations), regarding my child _____ DOB:_____ between Clearly Speaking, LLC and the following facilities:

1. Name of facility:_____

   Address: _____
2. Name of facility: _____

   Address: _____
3. Name of facility: _____

   Address: _____

_____ _____

Signature Date

HIPAA NOTIFICATION

I am required by law to maintain the privacy of protected health information, give you a notice of our legal duties and privacy practices regarding health information about your child, and follow the terms of the attached notice.
By signing this document you acknowledge receipt of the privacy policy as it relates to protected health information about your child's treatment, payment and health care operations. You have the right to request restrictions, which must be made in writing to Clearly Speaking, LLC, 87 Lafayette Rd. Unit 3, Hampton Falls, NH 03844.

_____ _____

Signature Date

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Financial Agreement

As a courtesy, Clearly Speaking, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.
It is the policy of Clearly Speaking that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. The office manager at your location will explain this information to you prior to your first visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.
If you are covered by health insurance with speech benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.
We highly recommend you also contact your insurance carrier and check into your coverage for speech therapy. Do not assume that you will not owe anything if you have more than one insurance policy.

Payment
Co-pays and treatment fees are due at time of service. Clearly Speaking accepts all major credit cards. Please make checks payable to Clearly Speaking, LLC.

Cancellations
Please provide Clearly Speaking with notice of cancellation more than 24 hours of a scheduled appointment. Cancellations that occur within 24 hours of the scheduled appointment will be charged $60 (this fee will not be covered by insurance). Any scheduled appointment missed without notice will be be charged $60. Clearly Speaking reserves the right to terminate treatment if there are three missed scheduled sessions.

_____ _____

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Insurance

I am responsible for any deductibles, co- pay's (due at the time of each session), or co-insurance payments associated with my insurance benefit. I understand that all service may be subject to an auditory review even after the service has been preformed and the claim paid. I understand that I am responsible for payments not covered by my insurance plan. I understand that my insurance company will be sent an itemized bill for therapy sessions in accordance to reasonable and customary charges. I understand that I must notify Clearly Speaking, LLC of any insurance changes immediately. _____(Initial)

It is the responsibility of the patient to verify coverage of services. For insurance holders that require a referral, you must contact your primary care provider and inform them that you have been referred to Clearly Speaking, LLC. This should be done prior to your child's first visit. If you have not followed these procedures and would still like to have your child seen, please understand that you will be responsible for any charges incurred if the referral is denied. _____ (Initial)

I understand that any information gained from insurance companies during verification of benefits, however, is not always guaranteed. It is imperative that families are aware of their insurance coverage and their potential responsibilities. _____(Initial)

_____ _____

Patient name printed Date of birth

_____ _____

Parent Signature Date

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Ongoing Authorization to Charge Credit Card

I hereby request and authorize Clearly Speaking to charge my credit card for all current and future amounts when due. Any appointment that is missed without 24 hours notice will be charged a fee of $60.

Card Type ( ) Visa ( ) Master Card ( ) Discover

Name on Card _____

Card Number _____

Verification (CVV) Number _____

Expiration Date _____

Card Billing Address _____

City_____ State_____Zip_____

Authorized by (Print Name) _____

Signature _____ Date_____