The Speech Pathology
Learning
Center

8514 W. Gage Blvd Kennewick, WA 99336

Tel: (509)73LOGIC {735-6422} Fax: (509) 735-2426

New Patient Packet

Prior to scheduling an appointment for an evaluation, we require three things

- A referral faxed to our office from the client's doctor
- A referral or pre-authorization request faxed from the doctor's office to insurance providers
- The results from a hearing test administered within the previous six months

To assist us in providing efficient care and to alleviate waiting time prior to your appointment, please help us by completing the following forms:

- Assignment of Benefits and Release of Information
- Authorization for Mutual Exchange of Information
- Consent to be Video Taped
- General Information Form
- Patient Insurance Information
- Patient Information Sheet

Co---Payments

Co-Payments are collected at each appointment as required by your insurance company. Please come to your appointments prepared to pay your co-payments. We accept cash, checks, Visa and MasterCard.

Appointments

We work very hard to ensure that our appointments occur at their scheduled time. Please be on time or early for your appointment. If you cannot make your scheduled appointment please let us know. We require 24 hours notice for a cancellation. If we are not notified at least 24 hours in advance of a cancellation you will be charged a $20 no-show fee. If the time you are scheduled for does not work for you, we will do our best to reschedule you at a more convenient day and time.

Case History

Patient Information **Date:**_____

Patient's Name:_____

Date of Birth:_____ Sex: ◯ M ◯ F Age:_____

Address: _____

City:_____State:____ Zip:_____

Email:_____

Home Phone:_____

Cell Phone: _____ Work Phone: _____

Occupation:_____

Employer:_____

Employers address: _____

Marital Status: ◯ Single ◯ Widowed ◯ Divorced ◯ Married ◯ Other

Spouse's Name:_____

Children (include names, sex, and ages):

_____

_____

_____

Who Lives in the Home?

_____

_____

_____

What Languages do you speak? If more than one, which one is your primary language?

_____

Existing Diagnosis:_____

Refferred by:_____

How did you hear about us?_____

Medical History

Please Check any of the following illnesses and conditions you may have had and provide the approximate age:

☐ Asthma	☐ Chicken Pox	☐ Convulsions	☐ Frequent colds
☐ Hearing loss	☐ Ear infections	☐ Noise exposure	☐ Otosclerosis
☐ Seizures	☐ High fever	☐ Tonsillitis	☐ Sinusitis

☐ Allergies to: _____

Please Check any of the following illnesses and conditions you may have had and provide the approximate age:

_____

_____

_____

Do you have any eating or swallowing difficulties? if yes, describe:

_____

_____

_____

List medications you are taking:

_____

_____

_____

List any major surgeries, operations, or hospitalizations and dates they occurred:

_____

_____

_____

Please provide any additional information that may be helpful in the evaluation or therapy process:

_____

_____

_____

Please return this form along with copies of any previous evaluations, or other reports you would like us to consider.

Thank You!

Patient Primary Physician

Physician's Name:_____

Practice Name:_____

Address:_____

Phone:_____ Fax:_____

Concerns

Describe the problem for which you are reffered and your concern as it relates to your speech, language, voice:

_____

_____

_____

What do you think may have caused the problem?

_____

_____

_____

When did you first notice the problem?

_____

_____

Has the problem changed since it was first noticed?

_____

_____

_____

Have you seen any other speech-language specialists? Who and when? What were the results?

_____

_____

_____

Have you seen any other specialist (physicians, psychologists, neurologists, etc.)? If yes, indicate the name, type of specialist, etc.

_____

_____

_____

Are there any other speech, language, learning, voice, or hearing problems in your family? If yes, please describe:

_____

_____

The Speech Pathology Learning Center

8514 W Gage Blvd Kennewick, WA 99336

Phone: 509-735-6442 Fax: 509-735-2426

Patient Insurance Information

Primary Insurance

Patient Name _____ DOB_____

Insurance Company _____Ph# _____

Identification Number_____Group Number _____

Subscriber Name_____ DOB_____SS #_____

Copayment $ _____Deductible amount $ _____ Out of pocket Maximum $ _____

Patient responsibility $ _____ Insurance Responsibility $ _____

Number of Allowable session's _____ per calendar year or other_____

Preferred Provided ◯ **Yes** ◯ **No** ◯ **In Network** ◯ **Out of Network**

Prior Authorization # _____

Secondary Insurance

Patient Name_____DOB _____

Insurance Company _____Ph#_____

Identification Number_____ Group Number_____

Subscriber Name_____ DOB_____ SS #_____

Copayment $ _____ Deductible amount $ _____Out of pocket Maximum $ _____

Patient responsibility $ _____ Insurance Responsibility $ _____

Number of Allowable session's _____ per calendar year or other_____

Preferred Provided ◯ **Yes** ◯ **No** ◯ **In Network** ◯ **Out of Network**

Prior Authorization # _____

THE SPEECH PATHOLOGY LEARNING CENTER, LLC
Washington License #LL00002194

PATIENT INFORMATION SHEET

Patient's Last Name	First Name	MI	Sex

Date of Birth	Social Security Number	Home Phone	Cell Phone	Other Phone

Address	City	State	Zip Code

School District/School	City	State	Zip Code

Billing Information

Parent/Spouse's Last Name	First Name	MI	Sex

Date of Birth	Social Security Number	Home Phone	Cell Phone	Other Phone

Address	City	State	Zip Code

Employer Name ☐ Unemployed ☐ Disabled	Employer City	State	Work Phone

E-mail	Driver's License #	State	Expiration

Who may we thank for this Referral?

Must Present Copy of Insurance Card

Primary Insurance Name	Identification Number	Group Number

Subscriber Name	Date of Birth	Social Security Number

Secondary Insurance Name	Identification Number	Group Number
Subscriber Name	Date of Birth	Social Security Number

Physician Information

Physician Office	Physician Name	Fax Number	Phone Number

Emergency Contact Information

In Case of Emergency Contact	Relationship	Phone Number

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance regardless of insurance coverage. I also authorize The Speech Pathology Learning Center or billing service or insurance company to release any information required to process my claims.

Signature of Patient_____ **Date Signed**_____

Signature of Parent/Legal Guardian_____**Date Signed**_____

For Office Use only

DX-CODES by priority

Code 1_____**Code2**_____**Code3**_____**Code4**_____

Assignment of Benefits and Release of Information

I, the undersigned certify that I (or my dependents) have insurance coverage

with_____ Name **of Insurance Company** (ies)
and assign directly to The Speech Pathology Learning Center, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize The Speech Pathology Learning Center, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. It is the responsibility of the client to determine all co-pays to be paid at the time of the visit and if you are unsure of your co-pay, you will be charged 50% of the visit cost at the time of the visit.

Responsible Party Signature: _____ **Relationship:** _____ **Date:** _____

Assignment of Benefits and Release of Information

I, the undersigned certify that I (or my dependents) have insurance coverage

with_____ **(Name of Insurance Company(ies))** and assign directly to The Speech Pathology Learning Center, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize The Speech Pathology Learning Center, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. It is the responsibility of the client to determine all co-pays to be paid at the time of the visit and if you are unsure of your co-pay, you will be charged 50% of the visit cost at the time of the visit.

Responsible Party Signature: _____ Relationship: _____ Date: _____

Cancellation Policy

Your appointment holds one of a limited number of client contact opportunities each day for your therapy session. Out of respect for your therapist and other therapy clients needing service, we require 24 hours notice of all cancellations. Clients will be billed for all appointments missed if at least 24 hours cancellation notice is not received. For your convenience, there is a 24 hour message service available on our regular phone number (509-735-6442) to leave a cancellation notice. The no-show fee is $35.00.

I further understand the majority of insurance companies do not pay for the no-show fee and that I will be personally responsible for payment of the no-show fee.

Acknowledged: _____ _____

Parent / Guardian / Responsible Party **Date**

Disclosure Information

Consent for Treatment:

Speech and/or Language therapy is dependent on many variables including an individual's physical, environmental and developmental history. Individual clients will respond uniquely to the treatment. We make no claims as to the anticipated results of treatment. Nevertheless, it is our intent to assist each client in defining what his/her problems are and to work towards satisfactory resolution of these problems as outlined within the scope of the Individual Treatment Plan.

Confidentiality:

All information about clients is held in strictest confidence. No information will be released without informed consent from you, except under special circumstances required by law.

I have read the above information and agree to consent to services. I agree that the outcome of my treatment is largely dependent on my effort. I indemnify and hold harmless, the therapist and The Speech Pathology Learning Center, LLC, from any and all claims arising directly or indirectly from the services rendered under this agreement. Such indemnification shall include reasonable attorney fees and costs.
I understand the terms for receiving services.
A copy of this disclosure information is available if requested.

Acknowledged: _____ _____

Parent / Guardian / Responsible Party **Date**

THE SPEECH PATHOLOGY LEARNING CENTER, LLC

DENISE CIARLO, CCC/SLP, MA

PHONE: (509) 735-6442

FAX: (509) 735-2426

AUTHORIZATION FOR MUTUAL EXCHANGE OF CONFIDENTIAL INFORMATION

I, _____, authorize the mutual exchange of confidential Information between The Speech Pathology Learning Center, LLC and the agencies listed below.

CLIENT: _____CLIENT'S DATE OF BIRTH: _____

SCHOOL: _____

DOCTOR: _____

DOCTOR: _____

OTHER: _____

OTHER: _____

OTHER: _____

_____ _____

SIGNATURE (Parent/Guardian) DATE

THE SPEECH PATHOLOGY LEARNING CENTER
8514 W Gage Blvd Kennewick, WA 99336
Phone: 509-735-6442 Fax: 509-735-2426

INFORMED CONSENT

Agreement To Pay for a Non-covered Services or Item
(For fee-for-services clients)

This form must be completed in full before providing a non-covered service or item to a _____ client.
Name of Insurance Carrier

CLIENT NAME: _____ ID Number: _____

- I understand that the specific services listed below ***may not*** be covered by my insurance carrier and are not included as part of another service, or have been determined by my insurance carrier to not be medically necessary.
- I choose to receive these specific services.
- I agree to pay for these specific services.

SPECIFIC SERVICES CLIENT AGREES TO RECEIVE AND PAY FOR:

_____

This agreements void and unenforceable, and I am under no obligation to pay the provider, if my insurance carrier covers the services listed above or if the provider fails to satisfy my insurance carrier conditions of payment as described within the insurance and provider contract.

I understand this form and all my questions were answered to my satisfaction.

_____ _____
SIGNATURE OF CLIENT/PARENT/GUARDIAN/ REPRESENTATIVE **Date**

_____ _____ _____
SIGNATURE OF PROVIDER **PROVIDER TAX ID#** **Date**

Note to Provider: The services or items listed above must be specific in nature. Document steps Taken to assure that the client fully understands this form and that the form has been interpreted and/or Translated, as necessary.

it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Your Individual Rights

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

(Vers. M1SSS04)

NOTICE OF PRIVACY PRACTICES*

We Care About Your Privacy

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

*These privacy practices are currently in effect and will remain in effect until further notice.

Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:
Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:
We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:
We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:
We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:
We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:
To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if

The Speech Pathology Learning Center

8514 Gage Blvd Kennewick, WA 99336

Phone: 509-735-6442 Fax: 509-735-2426

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

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

Name:_____

Birthdate:_____

Signature:_____

Date:_____