

BABEL THERAPY, PLLC

Patient Information and Financial Authorization

Patient Name: _____ **Date of Birth:** _____

(First) (Last) (Middle)

Address: _____
 (Street) (City) (State) (Zip)

Phone: Home: _____ Patient Social Security # _____ - _____ - _____

Cell: _____

***required for commercial insurance, Medicaid and**

Work: _____

Medicare billing

E-mail: _____

Patient: **Single ()** **Married ()** **Divorced ()**

Widowed () Dependent ()

Parent/Guardian Name: _____

Name of Insurance (PRIMARY):_____

Policy # _____ **Group #:** _____

Name of Insured: _____ **Relationship to Patient:** _____

Insured Party's Date of Birth: _____ **Insurance Phone:** _____

Employer: _____ Employer Phone: _____

Employer Address:_____

Name of Insurance (SECONDARY): _____

Policy # _____ **Group #:** _____

Name of Insured:_____ **Relationship to Patient:**_____

Insured Party's Date of Birth: _____ **Insurance Phone:** _____

Employer: _____ **Employer Phone:** _____

Employer Address: _____

IN CASE OF AN EMERGENCY

Notify: _____ **Phone:** _____

Cell () Home () Work ()

Relationship to Patient: _____

Name of Nearest Relative:_____ **Phone:**_____

Cell () Home () Work ()

Address _____

(Street) (City) (State) (Zip)

Payment In Full Is Required At Time of Service

I agree to be responsible for payment of services.

Signature

Date

I authorize release of any medical information necessary to process my claims.

Signature

Date

I authorize payment of medical benefits to Babel Therapy, pllc for services provided.

Signature

Date

Witness Signature

Date



Service Availability Notice

Dear Patient,

Thank you for your interest in our speech therapy services. We appreciate the opportunity to assist you in your communication and therapeutic needs.

At this time, **in-person speech therapy services are on hold for areas outside of Cypress, TX**, due to current scheduling and availability constraints. We apologize for any inconvenience this may cause and will notify you as soon as in-person appointments become available in your area.

However, we do have immediate openings for telehealth (virtual) speech therapy sessions for patients located outside of Cypress, TX. Telehealth services provide a convenient and effective way to receive therapy from the comfort of your home while working with our licensed clinicians.

If you are interested in scheduling a telehealth appointment or would like to be added to a waitlist for future in-person availability, please let us know by completing the section below or contacting our office directly.

We appreciate your understanding and look forward to serving you!

Patient Response Section

- ☐ **Yes, I am interested in telehealth services.** Please contact me to schedule an appointment.
- ☐ I am interested in services in the office located in Cypress.
- ☐ **I would like to be added to the waitlist for in-person services (outside Cypress, TX).**
- ☐ **I would like more information about telehealth services before deciding.**

Patient Name: _____

Contact Phone/Email: _____

Preferred Appointment Times: _____

Return this form to: referrals@babeltherapy.com



BABEL THERAPY FINANCIAL POLICY

Thank you for choosing our speech therapy services. Our goal is to provide high-quality care and support to all our patients. To ensure that we can continue to offer the best possible service, we have established the following financial policy:

1. Payments are due at the time of service: We require all patients to pay for services rendered at the time of their appointment. Payment may be made by cash, check, or credit card.
2. Card on file: We require all patients to have a valid credit card on file with us. This card will be used to process any outstanding balances that are not paid at the time of service.
3. Late payments: Any outstanding balance not paid within 30 days of the invoice date will result in a hold being placed on the patient's speech therapy services. This means that the patient will not be able to schedule or receive further treatment until the balance is paid in full.
4. Insurance payments: If we bill your insurance company for services rendered, we will provide you with a statement showing the balance owed after insurance payments have been applied. This balance must be paid within 30 days of the invoice date.
5. Financial assistance: If you are experiencing financial hardship and are unable to pay for services rendered, please speak to our billing department to discuss possible financial assistance options.

We understand that unexpected expenses can be a burden, and we strive to work with our patients to make payment arrangements that are feasible and fair. However, to maintain the high quality of care that we provide, we must enforce this financial policy.

Thank you for your cooperation and understanding. If you have any questions about our policy, please feel free to contact our billing department.

Client/Guardian Name: _____

Client/Guardian Signature: _____

Date:



Changing Lives Through Communication

17820 Mound Rd Ste F Cypress, TX 77433

Phone: 936.703.5064 Fax: 844.559.5504 www.babeltherapy.com

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____
CVV (3 digit # on back) _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature

Date



Attendance Policy for Speech Therapy

Effective Date: January 1, 2023

Purpose:

This attendance policy outlines the expectations for attendance and the consequences of repeated no-shows for speech therapy sessions at Babel Therapy. Our goal is to provide effective and consistent therapy services to all our clients. Regular attendance is crucial for achieving optimal outcomes and ensuring the progress and success of therapy sessions.

Attendance Requirements:

Clients are expected to attend all scheduled speech therapy sessions promptly and as agreed upon during the initial evaluation and subsequent scheduling discussions.

The attendance policy applies to both in-person and virtual (teletherapy) sessions.

If a client is unable to attend a scheduled session due to illness, emergency, or other valid reasons, it is their responsibility to notify their assigned speech therapist at least 24 hours in advance. Early notification allows us to reschedule the session and offer the time slot to another client in need.

No-Show Definition:

A no-show is defined as a scheduled session for which the client fails to attend without any prior notification or justification.

Policy Guidelines:

First No-Show:

The first no-show will be addressed with a reminder and a discussion with the client or their guardian (if applicable) to emphasize the importance of attendance and the impact it has on therapy progress. Documentation of the first no-show will be made in the client's record.

Second No-Show:

In the event of a second no-show within a rolling 30-day period, a written warning will be issued to the client or their guardian.

A meeting may be scheduled with the speech therapist to address any concerns or barriers the client may be facing that hinder regular attendance.

Documentation of the second no-show and the written warning will be recorded in the client's file.

Third No-Show:

A third no-show within a rolling 30-day period will be considered a serious violation of the attendance policy.

Upon the third no-show, the client will be discharged from therapy, and their case will be closed.

The client or their guardian will be notified in writing of the discharge decision and its rationale.

The client will be provided with resources for seeking alternative speech therapy services if desired.

Exceptions and Special Circumstances:

We understand that unforeseen circumstances and emergencies can arise, leading to occasional scheduling conflicts or last-minute cancellations. In such cases, we encourage clients to notify us as soon as possible so that we may work together to find a suitable solution and minimize the impact on therapy progress.

Appeals Process:

Clients have the right to appeal the discharge decision due to repeated no-shows. Appeals should be submitted in writing to the speech therapy department within 7 days of receiving the discharge notice.

The appeal will be reviewed by the appropriate personnel, and a decision will be communicated to the client or their guardian.

Review and Amendments:

This attendance policy will be periodically reviewed and updated as necessary to ensure its effectiveness and relevance. Any changes to the policy will be communicated to all clients in a timely manner.

By signing below, you acknowledge that you have read and understood the attendance policy for speech therapy at Babel Therapy.

Client/Guardian Name: _____

Client/Guardian Signature: _____

Date: _____

CONSENT TO COMPLY WITH FEDERAL HIPAA ACT

Patient Consent for Use and Disclosure of Protected Health Information

With my consent and signature, Babel Therapy, PLLC may use and disclose protected health information about me or my child to:

1. Carry out treatment, payment, and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care for me or my child.
3. Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc.) that will assist in practice of medical care for me or my child. Such correspondence is to be marked personal and confidential.
4. Send or transmit email to any location provided by me for all above similar items and purposes.
5. To use and/or disclose protected health information about me or my child to/with third parties involved in mine or my child's care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians, and laboratory personnel. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office of Babel Therapy, PLLC, I may revoke this permission; however, Babel Therapy, PLLC may decline to provide further treatment to me or my child. Babel Therapy, PLLC may also decline further treatment to me or my child should my restrictions on the type of third party information, in the center's opinion, impede medical care of me or my child.

I have the right to review the Notice of Privacy Practice Manual of Babel Therapy, PLLC. Babel Therapy, PLLC may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, a copy of such changes, should these changes directly relate to mine or my child's care.

I have the right to request that Babel Therapy, PLLC restrict how it uses or discloses mine or my child's health information. However, as stated previously, Babel Therapy, PLLC is not required to agree to my restrictions. If Babel Therapy, PLLC accepts my restrictions, Babel Therapy, PLLC is then bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent, or revoke this consent, Babel Therapy, PLLC, in their sole discretion, may decline further treatment for me or my child.

The Federal HIPAA (Privacy Act) of 2001 was created to protect mine and my child's health information. I understand this must be accomplished within the provisions and rules set up by Babel Therapy, PLLC to fulfill federal law. I may request to review the manual which spells out these provisions. Babel Therapy, PLLC will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, Babel Therapy, PLLC may decline to provide further care. Babel Therapy, PLLC will strive to provide information so that I may make an informed decision concerning the privacy of mine or my child's medical information.

Signature of Parent or Legal Guardian of Minor Child

Patient's Name

Date of Birth

Date of Signature

Printed Name of Signature Above

Initials of Witness

Text Messaging Privacy Policy

We are committed to protecting your privacy when communicating via text. This policy explains how we collect, use, and protect your information.

What We Collect:

When you text us, we may collect:

- Your name, phone number, and email
- Health information such as diagnosis, treatment plans, and progress notes

How We Use It:

- To communicate about speech therapy
- To send appointment reminders and scheduling info
- To answer your questions
- To monitor progress and adjust care

How We Protect It:

- We use secure, HIPAA-compliant messaging tools
- Only authorized staff can access your information
- We regularly review our privacy practices

When We Share It:

We do **not** share your info without your permission, unless:

- Required by law (e.g., court order)
- Needed for your care, with your consent
- Required by your insurance, with your consent

Your Rights:

You have the right to:

- Access and get a copy of your information
- Request changes or limits on how it's used
- File a complaint if your rights are violated

Questions?

Call us at **936-703-5064** with any questions.

Signature: _____

Date: _____



Telehealth Consent Form

What is Telehealth?

Telehealth lets you receive speech therapy from home using a phone, computer, or tablet. You meet with your therapist through video or audio instead of going to a clinic.

How Does It Help?

- Easy access to therapy from home
- No travel or exposure to illness

What Are the Risks?

- It may feel different than in-person sessions
- Technical issues could disrupt sessions
- Your therapist may ask you to come in for an in-person visit if needed
- Privacy could be affected if others are nearby during your session

Privacy & Security

- Sessions are not recorded
- Use a private space and secure internet
- Our platform is HIPAA-compliant and protects your information

Cost

- Telehealth costs the same as in-person visits
- You may be responsible for copays or deductibles, based on your insurance
- If an in-person visit is needed later, that may be billed separately

By signing below, you agree that:

- You understand the benefits and risks of telehealth
- You've had the chance to ask questions
- You give consent to receive speech therapy via telehealth

Signature: _____

Date: _____



Babel Therapy Telehealth Privacy Policy for Speech Therapy

Effective Date: January 1, 2023

Purpose:

Babel Therapy, PLLC is committed to protecting your privacy during telehealth speech therapy sessions in compliance with all applicable laws.

Secure Platform:

We use a HIPAA-compliant telehealth platform designed to safeguard your personal health information.

Confidentiality:

All information shared is confidential. Sessions are conducted in secure, private settings, and we use encryption and secure data storage to protect your information.

Client Consent:

Written consent is required before starting telehealth services. Clients acknowledge potential risks, such as technical issues or limited environmental control. Consent can be withdrawn at any time in writing.

Limits of Confidentiality:

Information is only shared with your written permission or when legally required (e.g., risk of harm, abuse, or court order).

Data Retention:

Records are kept as required by law and for a reasonable period thereafter to ensure continuity and legal compliance.

Client Rights:

Clients may access, request corrections to, or file complaints about their records by contacting our privacy officer.

Policy Updates:

We periodically update this policy and will notify clients of any significant changes.

By signing below, you acknowledge that you have read and understood the telehealth privacy policy for speech therapy at Babel Therapy, PLLC.

Client/Guardian Name: _____

Client/Guardian Signature: _____ Date: _____

BABEL THERAPY, PLLC

CURRENT MEDICATION LIST

Patient Name: _____

ID number: _____

Allergies: ☐ No Known Drug Allergies (NKDA) ☐ Food Allergies: _____

☐ Other: _____

Date	Medication	Dosage/Frequency	Route of Administration

Speech-Language-Hearing Case History Form

Child's Name:	Birthdate:
Sex: M F	Age:
Mother's Name:	Mother's: Cell #: Home #: Work #:
Mother's Address:	Mother's: Home email: Work email:
Father's Name:	Father's : Cell #: Home #: Work #:
Father's Address:	Father's : Home email: Work email:
Doctor's Name:	Doctor's Phone:

Child lives with (check one):

- ☐ Birth parents
 ☐ Foster Parents
 ☐ One Parent
☐ Adoptive Parents
 ☐ Parent & Step-Parent
 ☐ Other _____

Child's race/ethnic group:

Caucasian, Non-Hispanic Hispanic African-American
 Native American Asian or Pacific Islander Other _____

Family History:

Siblings: _____ Age: _____

Is there a past family history of speech, language or hearing problems or learning/developmental disabilities? ☐ Yes ☐ No

If "yes," please comment here:

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? _____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language: ☐ Yes ☐ No

Who speaks the language? _____

Which language does the child prefer to speak at home? _____

At school? _____

Birth & Medical History:

Was there anything unusual about the pregnancy or birth? ____ Yes ____ No

If yes, please explain:

How old was the mother when child was born? _____

How many months was the pregnancy? _____

Was the mother sick during pregnancy? _____

Birth Weight: _____

Has your child had any of the following:

Adenoidectomy ____

Allergies ____

Breathing Difficulties ____

Chicken Pox ____

Frequent Colds ____

Frequent Ear Infections ____

Ear (PE) Tubes ____

High Fevers ____

Head injury ____

Sleeping Difficulties ____

Thumb/Finger Sucking ____

Tonsillectomy ____

Tonsillitis ____

Vision Problems ____

If you checked any, please provide details/dates:

Other serious illness/injury: _____

Date of last hearing screening: _____ Results: _____

Date of last vision screening: _____ Results: _____

Hospitalizations: _____

Medications: _____

Developmental History:

Please tell the approximate age your child reached the following milestones:

_____ Sat Alone

_____ Babbled

_____ Said first word(s)

_____ Spoke in short sentences

_____ Completed toilet training

_____ Grasped crayon/pencil

_____ Crawled

_____ Put two words together

_____ Walked

Oral Motor & Feeding History:

Has your child experienced feeding/eating difficulties (e.g., biting, swallowing, chewing)? Yes/No _____

If yes, please explain: _____

Was your child breast-fed or bottle-fed? _____

Does your child eat by self using utensils? Yes/No _____ Drool? _____

Does your child put toys in mouth? Yes/No _____

If yes, please explain: _____

Does your child have food allergies? Yes/No _____

If yes, please explain: _____

Does your child have food preferences/aversions or food allergies? Yes/No _____

If yes, please explain: _____

Speech & Language Development:

How does your child prefer to communicate?

_____ gestures _____ words _____ both _____ neither

Number of words in a typical sentence? _____

Is your child's speech difficult to understand? _____

What types of speech errors does he/she exhibit?

Does your child: identify objects? _____ actions? _____
ask questions? _____ follow directions? _____
understand what you are saying? _____
respond correctly to yes/no questions? _____
respond correctly to "WH" (who, what etc.) questions? _____
play appropriately with toys? _____
have difficulty with routines and/or transitions such as bedtime, mealtime, or
getting in the car? _____

Please provide examples of your child's speech/language:

Has your child ever received a speech/language evaluation? Yes/ No _____
Date _____
Has your child received speech/language therapy previously? Yes/No _____
If yes, when? For how long?

Can your child have food for therapy and/or rewards? Yes/No _____
If yes, please list any exceptions:

Please indicate your current concerns:

Is your child aware of, or frustrated by, any speech/language difficulties? _____
What do you see as your child's most difficult problem in the home?

What do you see as your child's most difficult problem in school?

School History:

School: _____

Grade: _____ Teacher: _____

Has your child ever repeated a grade? _____ If so, what grade? _____

What are your child's strengths and/or best subjects? _____

Is your child having difficulty with a particular subject? _____

If yes, what subject? _____

Is your child receiving help at school or at home (i.e., support services, tutoring, etc.)? _____

Yes/No: _____ If yes, please explain: _____

Does your child have an IEP? _____ If so, please briefly describe the services your child receives: _____

(Please also provide a copy of the IEP at your first appointment)

Favorite Activities:

Please list your child's favorite activities, hobbies, toys, games, t.v. shows, etc.

What are their dislikes, if any:

What are your child's strengths?

Additional Concerns/Comments:

Thank you so much for your cooperation in completing this form, it is crucial that we have this information so that we can provide the most effective evaluation and therapy services for your child.

CONSENT TO EXCHANGE INFORMATION

If you wish Babel Therapy to share information with entities such as your school district please include their information below

Patient's Name: _____ Date of Birth: _____

Current Address: _____

Telephone Number(s): _____

I hereby give my consent for the Babel Therapy, PLLC to exchange information with:

(Name and Address of Agency/Individual)

Information exchanged may include but is not limited to speech/language and hearing records, medical reports, academic information and program planning. Information may be shared through written reports, by phone, fax or in person.

- ☐ All of the information I hereby authorize to be exchanged with the above will be held strictly confidential and cannot be released without my written consent. I understand that I have the right to inspect and copy the information to be disclosed. I understand that I may withdraw this authorization at any time.

This request is effective up to and including six (6) months from the date of signature.

By checking this box, you authorize Babel Therapy, PLLC to periodically send you, via email or U.S. mail, helpful information related to communication disorders, special promotions the Practice may have to offer, and/ information about special fundraising events to benefit the Practice.

Signature of Consenting Party

Relationship to Patient
(must be legal guardian/conservator)

Date