BABEL THERAPY, PLLC

Patient Information and Financial Authorization

Patient Name:_____ **Date of Birth:**_____
(First) (Last) (Middle)

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

Phone: Home: _____

Cell:_____

Work:_____

E-mail:_____

Patient Social Security #_____-_____-_____

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

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** ☐

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**

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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.

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

Client/Guardian Name: _____

Client/Guardian Signature: _____

Date: _____

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Phone: 936.703.5064 Fax: 844.559.5504 www.babeltherapy.com

Credit Card Authorization Form

REQUIRED FOR COVERAGE OF DEDUCTIBLES, COPAYS AND CO-INSURANCE
Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remaininеffectuntilcanceled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ 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 (tele-therapy) 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:

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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: _____

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: _____

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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: _____

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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: _____

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CURRENT MEDICATION LIST

Patient Name:_____ ID number:_____

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

☐Other:_____

Date	Medication	Dosage/Frequency	Route of Administration

CASE HISTORY - CONFIDENTIAL INFORMATION

Patient Name: _____

Today's Date: _____

Person completing this form: _____

Relationship to patient: _____

Who referred you to Babel Therapy? _____

Reason for Visit: _____

Medical Diagnosis: _____

Physician Name: _____ Phone Number: _____

Address: _____

MEDICAL HISTORY

List all hospitalizations and surgeries for the client, include overnight stays (medical or behavioral)

- No past hospitalizations or surgery

Reason for hospitalization/surgery	Age	Month/Year	Length of stay

Wears glasses? ☐YES ☐NO	Legally Blind ☐YES ☐NO
Hearing impairment ☐YES ☐NO If yes please describe	Wears hearing aids ☐YES ☐NO

☐ No serious illnesses or injuries in the **past** ☐ No serious illnesses or injuries **now**

Date	Age	Diagnosis/Illness	Past	Now	Date	Age	Diagnosis/Illness	Past	Now
		Serious Injuries	☐	☐			**Lung/breathing Problems**	☐	☐
		Serious head injury	☐	☐			Asthma	☐	☐
		Other serious injury	☐	☐			Pneumonia	☐	☐

		Loss of consciousness	☐	☐
		Sleep Problems	☐	☐
		Neurological Problems	☐	☐
		Birth abnormality	☐	☐
		Seizures (any type)	☐	☐
		Other: _____	☐	☐
		Vision Problem	☐	☐
		Vision problems at birth	☐	☐
		Requires glasses/contacts	☐	☐
		Other: _____	☐	☐
		Hearing Problem	☐	☐
		Hearing problems at birth	☐	☐
		Deafness	☐	☐
		Chronic ear infections	☐	☐
		Ear tubes	☐	☐
		Other: _____	☐	☐
Date	Age	Diagnosis/Illness	Past	Now
		Dental Problem	☐	☐
		Abnormally shaped/ missing	☐	☐
		Extractions/cavities	☐	☐
		Dental braces	☐	☐
		Other: _____	☐	☐
		Skin Problem	☐	☐
		Eczema	☐	☐
		Ash leaf patches	☐	☐
		Café-au-lait spots	☐	☐
		Other: _____	☐	☐
		Growth Problem	☐	☐
		Failure to gain weight	☐	☐
		Obesity	☐	☐
		Short stature	☐	☐
		Tall stature	☐	☐
		Other: _____	☐	☐
		Heart Problem	☐	☐
		Heart abnormalities at birth	☐	☐
		Heart surgery	☐	☐
		Heart rhythm abnormalities	☐	☐
		High blood pressure	☐	☐

		Apnea or irregular breathing	☐	☐
		Other: _____	☐	☐
		Stomach/bowel Problems	☐	☐
		Swallowing problems	☐	☐
		Gastroesphageal reflux	☐	☐
		Chronic abdominal pain	☐	☐
		Chronic diarrhea	☐	☐
		Chronic constipation	☐	☐
		Other: _____	☐	☐
		Kidney/Bladder Problems	☐	☐
		Abnormalities at birth	☐	☐
		Kidney/bladder infections	☐	☐
		Other: _____	☐	☐
		Muscle/bone/joint)	☐	☐
		Abnormalities at birth	☐	☐
		Scoliosis or spinal curvature	☐	☐
Date	Age	Diagnosis/Illness	Past	Now
		Circulatory Problem	☐	☐
		Anemia	☐	☐
		Sickle cell disease	☐	☐
		Chronic low platelet count	☐	☐
		Bleeding /bruising problem	☐	☐
		Other: _____	☐	☐
		Hormone Problem	☐	☐
		Sugar diabetes	☐	☐
		Early puberty	☐	☐
		Late or incomplete puberty	☐	☐
		Other: _____	☐	☐
		Mental Health problem	☐	☐
		ADHD	☐	☐
		Oppositional defiant disorder	☐	☐
		Anxiety disorder	☐	☐
		Obsessive-compulsive	☐	☐
		Depression	☐	☐
		Bipolar disorder (manic-	☐	☐
		Schizophrenia	☐	☐
		Tic disorder (e.g., Tourette)	☐	☐
		Intellectual disability	☐	☐

		Other: _____	☐	☐			Eating disorder (e.g.,	☐	☐
							Other: _____	☐	☐

Other Physical or Medical Conditions: _____

_____

_____

COMMUNICATION AND INTERACTION SKILLS:

1. Have any recent speech-language assessments been completed with the person yes | no
   What were the results?

2. How does the person answer yes/no questions? Describe.

3. Who best understands the person and why?

4. What is **your** estimate of the person's ability to: (describe)
   - understand directions/commands?
   - understand new words?
   - understand conversations of adults?
   - play with people his/her own age?
   - express general feelings?
   - express specific ideas, like why he/she is crying or the name of a person or thing he wants?
   - make choices

5. When the person is trying to tell you a specific idea (like something that happened at home), but he/she isn't being understood, does he/she ….

realize that he/she is NOT understood	yes | no Describe:
keep repeating until he/she is understood	yes | no Describe:
get angry or frustrated or cry	yes | no Describe:
quit and do something else	yes | no Describe:
quit and stop talking	yes | no Describe:
other:	yes | no Describe:

6. Describe how the person tells you when he/she ….

is feeling happy or sad?

is hungry or thirsty?
needs helps with something?
wants something to stop?
wants more of something?
wants a specific object?
wants a specific person?
wants to do something specific

7. What, if any kinds of, everyday technology or devices does the person use (or try to use)? Examples: TV remote control, iPad or other similar tablet, video game, electronic toys.

8. What specific **communication** questions and concerns do you want addressed during this assessment?

9. What long-term communication goals do you have for the person?

AUGMENTATIVE COMMUNICATION:

1. Does the person already use an ***augmentative communication device or mobile device with an app***? yes | no
   If YES, please name the device/app and who owns it.

2. Has ***sign language*** been used or is being tried? yes | no If YES, describe.

3. Does the person have a ***manual communication board, book or eye point display***? yes | no If YES, describe below:

What is the style of the manual system?	
What is the size of the board/book?	
How many words are in the board/book?	
How many words are there per page?	
How are the words represented?	
How does the person pick a word?	
How long has it been used?	
Who uses it with him/her?	
How is the system transported?	
Who made it and/or maintains it?	
Why does the person need more than this board, book, or display?	

4. Have any other AAC device(s) been tried or suggested? yes | no If YES, please describe them. Charts are provided for 2 trialed/suggested devices. Add a separate page if needed.

Name of the device(s)	
How did the person operate it?	
What size or how many keys were there?	
Where was it used?	
How long was it used?	
What was programmed in it?	
Is it being used now?	

Name of the device(s)	
How did the person operate it?	
What size or how many keys were there?	
Where was it used?	
How long was it used?	
What was programmed in it?	
Is it being used now?	

VOCATIONAL TRAINING and/or DAY PROGRAM:

1. Is the client receiving vocational training or attending a day program? yes | no Describe the vocational training or day program.

2. What does the client do at the training or day program?

4. Can the person read or write? yes | no Describe

5. Does the person have any experience using computers? yes | no Describe

6. Does the training or day program have any therapists who work or consult there who are willing to provide support for use of the person's communication device? yes | no If YES, who?

Please provide NAME, ADDRESS, CONTACT PERSON AND PHONE NUMBER for school or day hab program:

Independent Social Skills (formerly dayhab) Center Name	

Address					
Contact Person					
Phone Number					
Days Attended	MON	TUES	WED	THURS	FRI
ATTENDS Y/N					
ARRIVAL					
DEPARTURE					

Functional Skills

Please mark how the patient completes the following.

Skill	independently	with assistance	requires maximal assistance
dressing			
feeding self			
toileting			
personal hygiene			
Bathing/showering			
Walking			

Is the patient left or right handed?_____Able to use: open cup spoon straw

Any difficulty? (Y/N) Swallowing:_____Chewing:_____Drinking:_____

Blowing:_____Drooling:_____

With whom does the patient interact with on a regular basis?

Does the patient show unusual behavior (explain)?

Does the patient receive other therapies such as physical, occupational, behavioral therapy?

Type of therapy	Yes/No	frequency
Physical		
Occupational		
Behavioral		

What do you hope to have happen as a result of this evaluation?

Does the report need to be sent to specific agencies? If yes, provide

Agency Name	
Contact Name	
Address	
Phone	
Fax -	

Anything else you would like us to know?

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PH: 936.703.5064
FX: 1-844-559-5504

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 form 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, PLLCmay 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 state 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 HIPPA (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

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PH: 936.703.5064
FX: 1-844-559-5504

CONSENT TO EXCHANGE INFORMATION

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/ or information about special fundraising events to benefit the Practice.

_____ _____

Signature of Consenting Party **Relationship to Patient (must be legal guardian/conservator)**

_____

Date