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)

Babel Therapy payment of benefits authorization

Payment is required in full 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

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.

Babel Therapy
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: ◯ 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 (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: _____

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Text Messaging Privacy Policy

At Babel Therapy, pllc, we are committed to protecting the privacy and confidentiality of our clients' personal and health information. This privacy policy outlines how we collect, use, and protect the information we receive when communicating with clients via text messaging.

Collection of Information

When clients choose to communicate with us via text messaging, we may collect the following types of information:

- Personal information, including name, phone number, and email address
- Health information, including diagnosis, treatment plan, progress notes, and other related information

Use of Information We use the information collected through text messaging for the following purposes:

- To communicate with clients regarding their speech therapy treatment
- To provide appointment reminders and scheduling information
- To respond to client inquiries and requests for information
- To track client progress and adjust treatment plans as needed

Protection of Information We take the security and confidentiality of client information seriously and have implemented safeguards to protect against unauthorized access, disclosure, and misuse. These safeguards include:

- Using secure messaging platforms that are compliant with industry standards for privacy and security
- Limiting access to client information to authorized personnel only
- Regularly reviewing and updating our privacy policies and practices to ensure compliance with applicable laws and regulations

Disclosure of Information We do not disclose client information to third parties without the client's express consent, except as required by law or as necessary to provide treatment services. We may disclose client information in the following circumstances:

- When required by law or legal process, such as a court order or subpoena
- To other healthcare providers involved in the client's treatment, with the client's consent
- To insurance providers or other third-party payers, with the client's consent

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Client Rights

Clients have the following rights regarding their personal and health information:

- The right to access and receive a copy of their information
- The right to request corrections or updates to their information
- The right to request restrictions on the use and disclosure of their information
- The right to file a complaint if they believe their privacy rights have been violated

Contact Information If you have any questions or concerns about our privacy policy or the use of text messaging in speech therapy treatment, please contact us at 936-703-5064.

By signing below, you acknowledge that you have read and understood the text messaging 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 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

Revised 6/2013

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

BABEL THERAPY, PLLC

CURRENT MEDICATION LIST

Patient Name:_____ Medication List Attached ☐ _____

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

☐ Other:_____

Date	Medication	Dosage/Frequency	Route of Administration

GENERAL INFORMATION: (Print)

Client's Legal Name: _____ Date: _____

Client's Preferred Name (if different): _____

Client Preferred Pronouns: _____

Date of Birth: _____ Age: _____

Address: _____
(Street) City/State ZIP Code

Home Phone: _____ Cell Phone: _____

Email: _____

Language (Please check one): ❑ Monolingual ❑ Bilingual ❑ Multilingual Caregiver(s)

Languages Spoken: _____

Check all that apply:
❑currently employed ❑part time ❑full time ❑retired ❑disabled ❑student

Current Occupation: _____

Previous Occupation: _____

REFERRAL INFORMATION & DESCRIPTION OF THE PROBLEM

Who referred you to this clinic? (List name): _____

Profession of Person or Relationship to You: _____

Reason for Referral (Please check yes or no):

Reading: ❑Yes ❑No

Writing: ❑Yes ❑No

Speaking: ❑Yes ❑No

Listening: ❑Yes ❑No

Cognition: ❑Yes ❑No

Voice: ❑Yes ❑No

Other: ❑Yes ❑No

Please provide more information on any items checked "yes" above:

When did your communication problem first begin?

What are your goals for your communication? What would you like to be able to do better?

EDUCATIONAL HISTORY

Name of Last School Attended: _____

Number of Years You Attended School: _____Highest Degree Earned: _____

FAMILY HISTORY

Your current marital status: ❑ married ❑ single ❑ widowed ❑ other_____

Number of children you have: _____ What are their ages? _____

List the Names of Those Living with You	**Relationship to You (partner(s), child, friend, etc.)**
Name: _____	_____
Name: _____	_____
Name: _____	_____
Name: _____	_____

Do you have a developmental disability, syndrome or learning disability? ❑ No ❑ Yes (Describe)

Does anyone in your family have a developmental disability, syndrome, learning disability, or history of speech, language or hearing difficulties? ❑ No ❑ Yes (Describe)

MEDICAL HISTORY

Please check the "Yes" or "No" box to indicate whether you have/had any of the following:

Yes	No		Yes	No	
❑	❑	Diabetes	❑	❑	Frequent Colds
❑	❑	High Blood Pressure	❑	❑	Laryngitis/hoarseness
❑	❑	Thyroid Problems	❑	❑	Dental Problems
❑	❑	Heart Attack	❑	❑	Attention Deficit Disorder
❑	❑	Other Heart Disease	❑	❑	Mental Illness
❑	❑	Respiratory Problems (asthma, emphysema, other)	❑	❑	Schizophrenia
			❑	❑	Bipolar
❑	❑	Gastrointestinal (digestive problems)	❑	❑	Depression
			❑	❑	Fatigue
❑	❑	Reflux (GERD)	❑	❑	Stress
❑	❑	Allergies	❑	❑	Anxiety Disorder
❑	❑	Kidney Problems	❑	❑	Obsessive Compulsive
❑	❑	Arthritis	❑	❑	Asperger's/Social Language
❑	❑	Lupus	❑	❑	Congenital Disorder (List):
❑	❑	Stroke	❑	❑	Dyslexia
❑	❑	Traumatic Brain Injury (including concussion)	❑	❑	Viruses (HIV, Herpes, Hepatitis)
❑	❑	Epilepsy/Seizures	❑	❑	Stuttering
❑	❑	Parkinson's Disease	❑	❑	Hearing Problems
❑	❑	Tremors	❑	❑	Surgeries
❑	❑	Headaches	(list) _____		
❑	❑	Meningitis	❑	❑	Other Medical Diagnoses
❑	❑	Other Neurological Disorders	(list) _____		
❑	❑	Bleeding Disorders	(list) _____		
❑	❑	Cancer (List part of the body affected):_____			
❑	❑	Swallowing Difficulty (if yes, please describe the difficulty that you have/had swallowing)			

If you answered yes to any of the above, please explain and comment below.

Describe any special techniques, equipment, and compensations you use.

If you are seeking services for voice, how much do you use your voice daily? Please check all that apply:

- ❑ Typical daily convesation
- ❑ Cheering at concerts/sports
- ❑ Speaking over noise
- ❑ High phone use or conference calls
- ❑ Prolonged voice use (4+ hrs/ day)
- ❑ Leading meetings/trainings
- ❑ Public speaking
- ❑ Teaching/lecturing
- ❑ Calling out to people or pets
- ❑ Singing or acting
- ❑ Talkative
- ❑ Other _____

Do you have any known allergies? ❑ Yes ❑ No
(If yes, please list below)

List all medications taken on a regular basis:

List all previous hospitalizations, reason and dates (add a piece of paper if needed)

Have you ever been seen by any of the following specialists? Check all that apply:

- ❑ Neurologist
- ❑ Behavior Specialist
- ❑ Orthodontist
- ❑ Psychiatrist
- ❑ Physical Therapist
- ❑ Dietitian
- ❑ Audiologist
- ❑ Occupational Therapist
- ❑ Psychologist
- ❑ Ear Nose Throat Physician
- ❑ Other _____

Please list names/approximate dates/and reasons for all specialists you have seen in the past (add a piece of paper if needed)

COMMUNICATION HISTORY AND CURRENT STATUS

Please check all statements that apply to your communication disorder and elaborate:

- ❑ My communication problem interferes with my social activities.
- ❑ My communication problem interferes with my performance at work.
- ❑ My communication problem interferes with my home life.
- ❑ My voice does not reflect the "true me."
- ❑ My voice difficulties restrict my social life.
- ❑ I feel anxious when I know I have to use my voice or communicate.
- ❑ I have difficulty recalling the names of common objects, people or places.
- ❑ My communication is not easily understood by people I know.
- ❑ My communication is not easily understood by strangers.
- ❑ I frequently say the wrong sounds in words.
- ❑ I am concerned about how well people understand or perceive my voice or speech.
- ❑ My speech contains many word repetitions or prolonged sounds.
- ❑ I often run out of breath while talking.
- ❑ It takes a great amount of effort to talk; I have to concentrate to make my voice sound the way I want or communicate the way I want.
- ❑ I have difficulty reading.
- ❑ I have difficulty learning and remembering new information.
- ❑ I have difficulty remembering things that I need to do, such as appointments or tasks for work.
- ❑ I have difficulty paying attention while having a conversation or completing a task.
- ❑ I have difficulty thinking through problems to find solutions.

Have you ever been seen by a Speech/Language Pathologist (SLP)? ❑Yes ❑No

If yes, please provide reports.

Do you have a hearing loss? ❑ No ❑Yes

Do you wear a hearing aid? ❑ No ❑ Yes

Do you have any vision problems? ❑ No ❑ Yes

Do you wear eyeglasses or contacts? ❑ No ❑ Yes

What are your interests and activities that you enjoy?

Overall, I would rate my communication as:

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you have any other comments that may be helpful to us in planning your evaluation?

Please include any additional reports or information that might be helpful in the evaluation and/or remediation of your child's speech/language problem.

Person Completing Form: _____

Relationship to Client: _____

Signature of Legal Guardian (if applicable)_____ Date: _____

Signature of Client _____ Date: _____

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?	