

**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.**

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**Signature**

**Date**

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

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**Signature**

**Date**

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

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**Signature**

**Date**

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**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.

Client/Guardian Name: \_\_\_\_\_

Client/Guardian Signature: \_\_\_\_\_

Date:

\_\_\_\_\_



Changing Lives Through Communication

10226 Grape Creek Grove Ln 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 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, 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 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

# Babel Therapy Telehealth Privacy Policy for Speech Therapy

Effective Date: January 1, 2023

## Purpose:

This privacy policy outlines the procedures and measures in place to protect the privacy and confidentiality of client information during telehealth speech therapy sessions at Babel Therapy, PLLC. We are committed to maintaining the privacy and security of personal health information in compliance with applicable laws and regulations.

## Telehealth Platform:

Babel Therapy, PLLC utilizes a secure and HIPAA-compliant telehealth platform for speech therapy sessions. This platform is designed to safeguard the confidentiality and privacy of client information.

## Confidentiality and Security:

All client information shared during telehealth speech therapy sessions is considered confidential and will be treated with the utmost care and respect.

The speech therapist conducting the telehealth session will ensure that the session takes place in a private and secure location where unauthorized individuals cannot overhear or access the session.

Babel Therapy, PLLC has implemented technical and administrative safeguards to protect client information during telehealth sessions. These safeguards include encryption, secure data transmission, and secure storage of client records.

## Client Consent:

Prior to participating in a telehealth speech therapy session, clients or their legal guardians will be required to provide written consent acknowledging their understanding and acceptance of the telehealth privacy policy.

By participating in a telehealth session, clients or their legal guardians acknowledge that there are potential risks and limitations associated with telehealth, including, but not limited to, technical difficulties, unauthorized access, and the inability to fully control the security of the client's environment.

Clients or their legal guardians have the right to revoke their consent for telehealth services at any time by notifying Babel Therapy, PLLC in writing.

## Limits of Confidentiality:

The speech therapist will only share client information with other healthcare professionals or entities involved in the client's care with the client's written consent or as required by law.



There are circumstances where the speech therapist may be legally obligated to breach client confidentiality, including, but not limited to, instances where there is a risk of harm to the client or others, suspected child abuse, or court-ordered disclosure.

**Data Retention:**

Client information obtained during telehealth speech therapy sessions will be retained in accordance with applicable laws and regulations governing the retention of healthcare records.

Babel Therapy, PLLC will retain client information for the duration required by law and for a reasonable period thereafter to ensure compliance with legal obligations, facilitate continuity of care, and address any potential concerns or disputes.

**Client Rights:**

Clients have the right to access and request copies of their telehealth speech therapy records in accordance with applicable laws and regulations.

Clients have the right to request amendments or corrections to their telehealth records if they believe the information is inaccurate or incomplete.

Clients have the right to file a complaint if they believe their privacy rights have been violated. Complaints should be submitted in writing to Babel Therapy, PLLC's designated privacy officer.

**Amendments:**

This telehealth privacy policy will be periodically reviewed and updated as necessary to reflect changes in technology, regulatory requirements, and organizational practices. Any changes to the policy will be communicated to clients in a timely manner.

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: \_\_\_\_\_

# 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

## 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: \_\_\_\_\_

# 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

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

**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:

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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:

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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:

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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

\_\_\_\_\_ Grasped crayon/pencil

\_\_\_\_\_ Babbled

\_\_\_\_\_ Crawled

\_\_\_\_\_ Said first word(s)

\_\_\_\_\_ Put two words together

\_\_\_\_\_ Spoke in short sentences

\_\_\_\_\_ Walked

\_\_\_\_\_ Completed toilet training

**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: \_\_\_\_\_

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**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?

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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:

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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:

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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?

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

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

**Signature of Consenting Party**

**Relationship to Patient  
(must be legal guardian/conservator)**

\_\_\_\_\_

**Date**