

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 ☐

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

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: _____



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 remain in effect until canceled.

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: _____

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

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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Legally Blind <input type="checkbox"/> YES <input type="checkbox"/> NO
Hearing impairment <input type="checkbox"/> YES <input type="checkbox"/> NO	Wears hearing aids <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes please describe	

☐ 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	<input type="checkbox"/>	<input type="checkbox"/>			Lung/breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>
		Serious head injury	<input type="checkbox"/>	<input type="checkbox"/>			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
		Other serious injury	<input type="checkbox"/>	<input type="checkbox"/>			Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>

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

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

		Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			Eating disorder (e.g., _____)	<input type="checkbox"/>	<input type="checkbox"/>
							Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Other Physical or Medical Conditions: _____

COMMUNICATION AND INTERACTION SKILLS:

- Have any recent speech-language assessments been completed with the person yes | no
What were the results?
- How does the person answer yes/no questions? Describe.
- Who best understands the person and why?
- 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
- 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:

- 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?
3. Can the person read or write? yes | no Describe
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
dress			
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?

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

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