BABEL THERAPY, PLLC

Patient Information and Financial Authorization

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

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

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

Cell:_____ ***required for commercial insurance, Medicaid and**

Work:_____ **Medicare billing**

E-mail:_____ **Patient: Single** ☐ **Married** ☐ **Divorced** ☐

Widowed ☐ **Dependent** ☐

Parent/Guardian Name:_____

Name of Insurance (PRIMARY):_____

Policy # _____ **Group #:** _____

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

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

Employer:_____ **Employer Phone:**_____

Employer Address:_____

Name of Insurance (SECONDARY):_____

Policy #_____ **Group #:** _____

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

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

Employer:_____ **Employer Phone:**_____

Employer Address:_____

IN CASE OF AN EMERGENCY

Notify:_____ **Phone:**_____
Cell ☐ **Home** ☐ **Work** ☐

Relationship to Patient:_____

Name of Nearest Relative:_____ **Phone:**_____
Cell ☐ **Home** ☐ **Work** ☐

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

Payment In Full Is Required At Time of Service

I agree to be responsible for payment of services.

Signature **Date**

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

Signature **Date**

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

Signature **Date**

Witness Signature **Date**

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:

_____

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: _____

Babel Therapy
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PH: 936.703.5064
FX: 1-844-559-5504
www.BabelTherapy.com

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

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

Babel Therapy
Changing Lives Through Communication

Speech-Language-Hearing Case History Form

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

Child lives with (check one):

☐ Birth parents ☐ Foster Parents ☐ One Parent

☐ Adoptive Parents ☐ Parent & Step-Parent ☐ Other _____

Child's race/ethnic group:

☐ Caucasian, Non-Hispanic ☐ Hispanic ☐ African-American

☐ Native American ☐ Asian or Pacific Islander ☐ Other _____

Family History:

Siblings: _____ Age: _____

_____ _____

_____ _____

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

If "yes," please comment here:

_____

_____

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

If yes, which one? _____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language: ☐ Yes ☐ No

Who speaks the language? _____

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

At school? _____

Birth & Medical History:

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

If yes, please explain:

_____

_____

_____

How old was the mother when child was born? _____
How many months was the pregnancy? _____
Was the mother sick during pregnancy? _____
Birth Weight: _____

Has your child had any of the following:

Adenoidectomy ____
Allergies ____
Breathing Difficulties ____
Chicken Pox ____
Frequent Colds ____
Frequent Ear Infections ____
Ear (PE) Tubes ____
High Fevers ____
Head injury ____
Sleeping Difficulties ____
Thumb/Finger Sucking ____
Tonsillectomy ____
Tonsillitis ____
Vision Problems ____

If you checked any, please provide details/dates:

_____
_____
_____

Other serious illness/injury: _____
Date of last hearing screening: _____ Results: _____
Date of last vision screening: _____ Results: _____
Hospitalizations: _____
Medications: _____

Developmental History:

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

_____ Sat Alone
_____ Babbled
_____Said first word(s)
_____Spoke in short sentences
_____Completed toilet training
_____ Grasped crayon/pencil
_____ Crawled
_____ Put two words together
_____ Walked

Oral Motor & Feeding History:

Has your child experienced feeding/eating difficulties (e.g., biting, swallowing, chewing)? Yes/No _____
If yes, please explain:
_____
Was your child breast-fed or bottle-fed? _____
Does your child eat by self using utensils? Yes/No _____ Drool? _____
Does your child put toys in mouth? Yes/No _____
If yes, please explain: _____
Does your child have food allergies? Yes/No _____
If yes, please explain: _____
Does your child have food preferences/aversions or food allergies? Yes/No ____
If yes, please explain:
_____

<u>Speech & Language Development</u>:

How does your child prefer to communicate?
_____ gestures _____ words _____ both _____ neither
Number of words in a typical sentence? _____
Is your child's speech difficult to understand? _____
What types of speech errors does he/she exhibit?

_____
_____

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

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

_____
_____
_____
_____

Has your child ever received a speech/language evaluation? Yes/ No _____
Date_____
Has your child received speech/language therapy previously? Yes/No _____
If yes, when? For how long?
_____
Can your child have food for therapy and/or rewards? Yes/No _____
If yes, please list any exceptions:
_____
Please indicate your current concerns:

_____
_____
_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

School History:

School: _____
Grade: _____ Teacher: _____
Has your child ever repeated a grade? _____ If so, what grade? _____
What are your child's strengths and/or best subjects? _____
Is your child having difficulty with a particular subject? _____
If yes, what subject? _____
Is your child receiving help at school or at home (i.e., support services, tutoring, etc.)?
Yes/No:_____ If yes, please explain: _____
Does your child have an IEP? _____ If so, please briefly describe the services your child receives:

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

Favorite Activities:

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

_____
_____
_____
_____
_____

What are their dislikes, if any:

_____
_____
_____

What are your child's strengths?

_____
_____
_____
_____

Additional Concerns/Comments:

_____
_____
_____
_____

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

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FX: 1-844-559-5504
www.BabelTherapy.com

CONSENT TO EXCHANGE INFORMATION

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

Patient's Name: _____ Date of Birth: _____

Current Address: _____

Telephone Number(s): _____

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

(Name and Address of Agency/Individual)

_____

_____

_____

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

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

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

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

Signature of Consenting Party

Relationship to Patient
(must be legal guardian/conservator)

Date