Thank you for choosing C.L.A.S.S., Inc. to help you meet your child’s communication needs. I realize that there are many options for speech therapy and I appreciate the opportunity to work with your child.

In the following packet, please find the New Client Forms. These forms include important information regarding case history, payment, communication and privacy. Please fill out the forms and return them to C.L.A.S.S., Inc. as soon as possible. If there is any prior paperwork for your child including prior testing, ARD paperwork, or IEPs, please turn in those papers at the same time.

I look forward to working with you and your child to meet his or her communication needs.

Jennifer Schababerle, M.S. CCC-SLP

License #18503

**Contact Information**

At times, I may need to contact you for appointment reminders or other concerns. Please complete only the items below that you authorize as a method of contact.

|  |  |  |  |
| --- | --- | --- | --- |
| Mother’s cell phone |  | Ok to leave a message? |  |
| Mother’s work phone |  | Ok to leave a message? |  |
| Mother’s email |  | Ok to leave a message? |  |
| Father’s cell phone |  | Ok to leave a message? |  |
| Father’s work phone |  | Ok to leave a message? |  |
| Father’s email  |  | Ok to leave a message? |  |

Please circle your preferred contact method for each item below:

|  |  |  |  |
| --- | --- | --- | --- |
| Correspondence: | Mother’s email | Father’s email | Phone |
|  |  |  |  |
| Invoices: | Mother’s email | Father’s email | Do not send invoice by email |

**Party Responsible For Payments:**

Personal Information:

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  |  |  |
| Address: |  |  |  |
| Phone: |  |  |  |

**Policies and Procedures**

**Appointments**

If you must cancel an appointment that you have scheduled, please contact me immediately. I can be contacted by email or phone. Except under extreme circumstances, all appointments not cancelled by 8:00 the morning of the appointment will be subjected to a $35 dollar service fee. In the event that you arrive late for your appointment, I will do my best to see you, however, the appointment may be shortened due to time constraints; the full session fee applies.

**Confidentiality**

Your privacy is important to me. I strongly recommend that you review the Notice of Privacy Policy for important details regarding policies maintaining confidentiality. In particular, I will only contact you via the means of communication that you have authorized in the new client forms. If you would like me to exchange information with persons other than yourself, an Authorization for Release of Information form must be completed.

**Fees**

I will always inform you of any charges prior to providing any type of clinical service. Fees apply to various types of services including direct client contact (clinic based or offsite), phone consultations, travel, and consultation with other professionals.

**Payment**

The person who completes the Party Responsible for Payment section is responsible for payment of all services rendered. Payment may be made at the time services are rendered or at the end of the month. Invoices are generated at the end of each month. Accounts more than 30 days overdue will be subject to $20 late fee. Accounts more than 60 days overdue will be sent to collection. I may at times provide discounts or fee waivers for families with extenuating circumstances.

**Termination of Services**

In the event that you do not keep your financial obligations to C.L.A.S.S., Inc. and remain delinquent on your account for more than 60 days, services will be suspended until payment is received. Service may also be terminated if it is determined that continued participation will be a detriment to the child or their family.

**Health Policy**

Help and cooperation is required in order to maintain a healthy environment. A child must be temperature-free for 24 hours before returning to therapy. If your child has vomiting and/or diarrhea, he/she should not return to therapy until 24 hours have passed since the last episode of the same.

Children will not be seen if any of the following is present:

* Too ill or uncomfortable to function in the therapy setting;
* Thick or discolored nasal discharge;
* Excessive sneezing or coughing and mucus-producing cough;
* An elevated temperature.

**Notice of Privacy Policies**

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

**Our Legal Duties**

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. C.L.A.S.S., Inc. is required to abide by these policies until replaced or revised. C.L.A.S.S., Inc. has the right to revise our privacy policies for all medical records, including records kept before changes take place. The contents of material disclosed to us in an evaluation, therapy session, or consultation are covered by the laws as private information. C.L.A.S.S., Inc. respects the privacy of the information you provide us and we abide by the ethical and legal requirements of confidentiality and privacy of records.

**Use of Information**

Information about you may be used by the personnel associated with C.L.A.S.S., Inc. for diagnosis, treatment planning, treatment, and continuity of care. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian or personal representative. It is the policy of C.L.A.S.S., Inc. not to release any information about a client without a signed release of information except in certain emergencies or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

**Public Safety**

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions , military, and when complying with worker’s compensation laws.

**Abuse**

If a client suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

**In the Event of a Client’s Death**

In the event of a client’s death, the spouse or parents of a deceased client have a right to access their child or spouse’s records.

**Professional Misconduct**

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional’s actions, related records may be released in order to substantiate disciplinary concerns.

**Judicial or Administrative Proceedings**

Health care professionals are required to release records of clients when a court order has been placed. In the event of a court order, only the minimally acceptable amount of information will be revealed. Additionally, if a client files a complaint or a lawsuit against anyone affiliated with C.L.A.S.S. Inc.; relevant information regarding the client may be disclosed for the purpose of formulating an appropriate defense.

**Minors/ Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access a client’s records unless it is determined that access would have a detrimental effect on the therapeutic relationship, or on the client’s physical safety or psychological well-being.

**Other Provisions**

When payment for services is the responsibility of the client, or a person who has agreed to providing payment and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client’s credit report may state the amount owed, the time-frame, and the name of the clinic or the collection source.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

Communications with the client outside the clinic setting will only occur as authorized by the client. When it is necessary to contact the client via telephone, messages will not be left on voicemails (or with persons other than the client or the client’s legal guardian) unless C.L.A.S.S., Inc. has received written authorization to do so.

**Your Rights**

* You have the right to cancel a release of information by providing C.L.A.S.S., Inc. a written notice.
* You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.
* You have the right to request that information about you be communicated by other means or to another location.
* You have the right to disagree with the records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.
* You have the right to know what information in your record has been provided to whom.
* You have a right to request a copy of this notice.
* You have the right to refuse or terminate services at any time for any reason. Your participation in services is voluntary.
* You have the right to privacy. Please see our Notice of Privacy Policy for information regarding certain limits to confidentiality and how your protected health information will be used.
* You have the right to know under what conditions we will terminate services. Please refer to C.L.A.S.S., Inc. Policies and Procedures for this information.
* You have the right to be informed of any changes in our policies. You will always be notified in the event that we change a policy that is relevant to the services that we provide to you.

**Consent/ Payment Form**

This form must be completed before services can be initiated. If the client is under the age of 18, the form must be signed by the legal guardian.

**Consent for Treatment**

I hereby attest that I have voluntarily applied for and entered into treatment, or give my consent for the minor or person under my legal guardianship, at C.L.A.S.S., Inc. I understand that I may terminate these services at any time.

**Receipt of Policies and Procedures**

I hereby attest that I received a copy of the Clients Rights notice, including payment policies, and have read, understand and consent to be bound by its content.

**Receipt of Patient’s Rights**

I hereby attest that I received a copy of the Patient Rights notice, have read, and understand its content.

Receipt of Privacy Policy and Consent for Disclosure of Health Information

I have been provided a copy of C.L.A.S.S., Inc.’s Notice of Privacy Policies detailing how my medical record may be used and disclosed. I understand that as a part of treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax and email only to the appropriate parties. I fully understand and accept the terms of this consent and acknowledge the receipt of the privacy notice. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, C.L.A.S.S., Inc. may refuse to treat me. I further understand that C.L.A.S.S., Inc. reserves the right to change its privacy policies and will provide me with a copy of any revised notice.

**Photocopy Authorization**

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (if over 18 years of age) Date

For Minors:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian Signature Date