

SPEECH THERAPY ASSOCIATES

Barbara Schwartz-Thorne M.A. CCC-SLP

Patient Information

PLEASE PRINT CLEARLY

Legal Name: _____ Chosen Name: _____

Date of Birth: _____ SSN: _____

Address: _____ Apt/Space/Unit: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell: _____ Other: _____

Email: _____ Opt-In for email and/or text messaging: Yes ☐

Emergency Contact: _____ Phone: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

Parent/Guardian/Spouse/Partner Information

Legal Name: _____ Chosen Name: _____

Date of Birth: _____ SSN: _____

Home #: _____ Cell: _____ Other: _____

**** INSURANCE INFORMATION ****

Primary Ins Company: _____ Phone: _____

Policyholder's Name: _____ DOB: _____

Policyholder's SSN: _____ ID#: _____ Group#: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

Second Ins Company: _____ Phone: _____

Policyholder's Name: _____ DOB: _____

Policyholder's SSN: _____ ID#: _____ Group#: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

PLEASE READ THE FOLLOWING CAREFULLY:

All deductibles, co-payments, and applicable charges will be due at the time of service, **NO EXCEPTIONS**. I hereby authorize the release of information necessary to file a claim with my insurance company. The above information is complete and correct. I assign benefits otherwise payable to me, to Speech Therapy Associates. All professional services rendered are charged to the patient. **The patient is responsible for all fees regardless of insurance coverage.** In the event of collection proceedings due to lack of payment, I agree to pay all collection fees that may be added to my account to recover money due.

Patient/Guardian Signature: _____ Date: _____

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IMPORTANT INFORMATION ABOUT YOUR VISITS AND THERAPY SESSIONS

PLEASE NOTE: IF YOU ARRIVE **10** MINUTES OR LATER FOR YOUR SCHEDULED APPOINTMENT **YOU WILL NOT BE SEEN.** THE APPOINTMENT WILL BE CANCELED AND RESCHEDULED. TWO OR MORE LATE ARRIVALS WILL RESULT IN DISCHARGE AND THE REFERRING PHYSICIAN WILL BE NOTIFIED.

YOUR INSURANCE IS ULTIMATELY YOUR RESPONSIBILITY

PLEASE REVIEW THE FOLLOWING:

- DOUBLE CHECK WITH YOUR INSURANCE COMPANY TO DETERMINE IF **AUTHORIZATION** IS REQUIRED FOR YOUR VISIT. EVALUATION CODES: 92521-92524, 92610, 92611 TREATMENT CODES: 92507, 92526
- **PLEASE NOTE AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE REVIEWED AT THE TIME THE CLAIM IS SUBMITTED.**
- IF YOUR VISIT IS DENIED FOR **ANY REASON**, YOU WILL BE BILLED FOR THE SERVICES.
- WE ARE **NOT** RESPONSIBLE FOR CHECKING YOUR BENEFITS, THIS IS A COURTESY AND WE CAN NOT GUARANTEE ANY INFORMATION WE RECEIVE FROM THE INSURANCE COMPANY.

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- ALTHOUGH THERE IS A 24-HOUR CANCELLATION POLICY WE REALIZE AN EMERGENCY CAN OCCUR AND ASK THAT YOU CALL US AS SOON AS YOU CAN TO NOTIFY US OF ANY NEED TO CANCEL YOUR APPOINTMENT.
 - IN ADDITION, IT IS OUR POLICY IF YOU OR YOUR CHILD ARE SICK THAT YOU CANCEL YOUR APPOINTMENT AS TO NOT SPREAD GERMS TO OTHER PATIENTS AND STAFF.
 - FOR YOUR CONVENIENCE WE DO HAVE A 24-hour ANSWERING MACHINE AVAILABLE TO ACCEPT CALLS WHEN OUR OFFICE IS CLOSED. PLEASE LEAVE A DETAILED MESSAGE INCLUDING THE PATIENT'S NAME, APPOINTMENT DATE, AND CALL-BACK INFORMATION.
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Please review our posted Privacy Policy Notice. This Notice of Privacy Practices provides detailed information about how we may use and disclose your medical information with or without authorization as well as more information about your specific rights concerning your medical information.

*******Please feel free to clarify any questions with our staff. *******

I HAVE READ, UNDERSTOOD, AND AGREE TO THE ABOVE INSURANCE/OFFICE POLICIES. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR THEIR INSURANCE REQUIREMENTS.

PATIENT/GUARDIAN/POA PRINTED NAME

SIGNATURE

DATE

NO-SHOW, LATE CANCELLATION, AND COLLECTION CHARGES

All no-show appointments canceled less than 24 hours in advance are subject to the patient being charged in full for that missed appointment. It is further understood that this fee is not a Medicare, Medicaid, or commercial insurance benefit and that it is the patient/guarantor's responsibility to pay the no-show charge and/or late cancellation charge.

NO-SHOWS

The charge for the missed appointments will be as follows:

1. Missed appointments (a) 1/2 Hour Session \$80 cancellation fee. b) 1 Hour Session \$160.00 cancellation charge)
2. After the second no-show, the patient will be discharged, and the referring physician will be notified.

LATE CANCELLATIONS:

1. Less than 24-hour cancellations are subject to the same fees as listed above.
2. **We have a 24-hour answering machine available to accept calls when our office is closed.**
3. After 2 or more late cancellations the patient will be discharged, and the referring physician will be notified.

COLLECTION FEE:

In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay **all** collection/legal fees that may be added to my account.

I have read, understood, and received a copy of this policy.

PATIENT/GUARDIAN/POA PRINTED NAME

SIGNATURE

DATE

RELEASE OF INFORMATION

I HEREBY AUTHORIZE CORRESPONDENCE, EITHER BY
PHONE, FAX, EMAIL, OR MAIL REGARDING:

(PATIENT NAME & DOB)

BETWEEN SPEECH THERAPY ASSOCIATES AND THE FOLLOWING OFFICE(S) (PLEASE LIST THE MEDICAL
PHYSICIAN OFFICES THAT YOU WOULD LIKE TO RECEIVE RECORDS, IF REQUESTED) and/or PERSON(S):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Please disclose the following information from my medical chart:

☐ **Eval/Consult Report** ☐ **Progress Notes**

☐ **Complete Medical Records** ☐ **Other:** _____

Please note: _____ has Durable Power of Attorney for my

☐ Medical and/or ☐ Financial care (please select one or both if applicable)

Patient/Guardian Signature: _____ Date: _____

POA (if Applicable) Signature: _____ Date: _____

**** For AETNA and BCBS-insured patients ****

Please be aware that your insurance may deem your diagnosis to be experimental or medically unnecessary. We will do our best to get the claims appealed if they are denied, but if these attempts fail, you will be responsible for the payment of the services provided.

******* Please feel free to clarify any questions with our staff. *******

- ☐ I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE INSURANCE/OFFICE POLICIES.
I ACKNOWLEDGE THE PATIENT IS ULTIMATELY RESPONSIBLE FOR THEIR INSURANCE BENEFITS AND REQUIREMENTS.
- ☐ I HAVE READ, UNDERSTAND, AND ACKNOWLEDGE THAT I DO NOT HAVE EITHER AETNA OR BCBS INSURANCE AND THIS STIPULATION SHOULD NOT APPLY TO MY SERVICES.

PATIENT/GUARDIAN/POA PRINTED NAME

SIGNATURE

DATE

PRIVACY NOTICE

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- ❖ Your confidential healthcare information may be released to other healthcare professionals within the practice to provide you with quality healthcare.
- ❖ Your confidential healthcare information may be released to your insurance provider for the practice receiving payment for providing you with needed healthcare services.
- ❖ Your confidential healthcare information may be released to the public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime, or domestic violence.
- ❖ Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- ❖ Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- ❖ Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- ❖ Your confidential healthcare information may be released only after receiving written authorization from you.
- ❖ You may revoke your permission to release confidential healthcare information at any time. You may be contacted by the practice to remind you of any appointments, healthcare treatment options, or other health services that may be of interest to you.
- ❖ You have the right to restrict the use of your confidential healthcare information. However, the practice may choose to refuse your restriction if it conflicts with providing you with quality healthcare or in the event of an emergency.
- ❖ You have the right to receive confidential communication about your health status.
- ❖ You have the right to review and photocopy any/all portions of your healthcare information. You have the right to amend your healthcare information.

RECORDS RETENTION

Health Care Records:

NRS 629.051 Retention of records; disclosure to patients concerning destruction of records; exceptions; regulations.

A healthcare provider must retain patient records for 5 years. In the case of a minor patient, the records must be retained until the patient turns 23 years old. Records may be retained in their original form, computer disc, magnetic tape, or via microfilm or similar technology.

Client Copy