



Sudbury Speech and Language Therapy, LLC

12 King Philip Rd. Sudbury, MA 01776

www.sudburyspeech.com

info@sudburyspeech.com

(585) 747 - 9902

Dear Parents,

In order to get started with speech therapy services including screening, evaluation, and treatment, we ask that you submit the following registration paperwork to **Sudbury Speech and Language Therapy, LLC**:

Signed copies of the following forms:

- Notification of Legal and Privacy Policies
- Insurance Policy, Payment Policy & Agreement
- Cancellation Policy
- Permission Form
- Consent for Release of Information
- HIPPA Authorization
- Case History Form

Please complete the Case History Form to the best of your ability. This will help us better understand the needs of the patient.

You may mail or e-mail the completed and signed initial paperwork to:

Sudbury Speech and Language Therapy, LLC
12 King Philip Rd
Sudbury, MA 01776

Email: info@sudburyspeech.com

We look forward to working with you to facilitate and improve your child's speech and language skills. Please do not hesitate to call us at (585) 747-9902 if you have any questions about the required forms or about our speech therapy services in general.



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NOTIFICATION OF LEGAL & PRIVACY POLICIES

- Speech therapy services are provided by Massachusetts licensed and ASHA-certified (holder of certificate of clinical competence) speech language pathologists.
- Sudbury Speech and Language Therapy, LLC will not be held responsible for any claims or damages of any kind, for injury to any person or persons, and/or for any damages due to loss of property arising directly or indirectly out of participation in these therapy sessions.
- Evaluation reports, progress reports, therapy goals, and therapy plans will be sent to outside sources (i.e. doctor's offices, insurance providers, schools) in a private manner, if applicable.
- Unless required by law:
 - o All patient information will be kept confidential in a secure location away from public access and will not be shared; and,
 - o Private information will not be shared with outside sources or professionals without written approval
- We will share your information when we are required to by federal, state, or local law. We will also share information if we are asked by the police or courts.
- This is the entire agreement and no promises outside of the agreement made on or before the effective date will be binding upon the parties.
- The invalidity or unenforceability of any provisions of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, which shall remain in full force and effect.

Patient/Parent/Guardian Signature

Date

Patient/Parent/Guardian Printed Name



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INSURANCE POLICY, PAYMENT POLICY, AND AGREEMENT

Sudbury Speech and Language Therapy, LLC will proceed with billing for services rendered for those insurance companies and plans for which we are in network providers. With this billing option, you may be responsible for a co-pay which will be due at the time of service. You will be responsible for any deductibles that apply. Furthermore, should your insurance carrier deny or fail to pay your claim, or fail to pay your claim in full, you as the parent/guardian will be responsible for payment of the services and/or the payment balance which was not covered by insurance.

We also accept private/out-of-pocket payment in the form of cash, check (made payable to: Sudbury Speech and Language Therapy, LLC), or credit card. **Sudbury Speech and Language Therapy, LLC** can provide patients/parents or guardians with a detailed invoice for services rendered. It is the responsibility of the patient/parent or guardian to file all insurance claims. Please note that it is the responsibility of the patient/parent or guardian to contact his or her insurance carrier to determine the required documentation for filing insurance claims.

Payment is expected at the time of service unless prior arrangements have been made. If payment is not received, a reminder will be sent out. Failure to make any payment will result in services being put on hold until payments are received and your account is paid in full. There will be a \$25.00 fee for all returned checks.

The rate of evaluations and/or therapy are subject to change.

We ask that patients/parents or guardians also notify **Sudbury Speech and Language Therapy, LLC** of physician or insurance coverage changes.

As the patient/parent or guardian of the patient, I have read the above information and understand **Sudbury Speech and Language Therapy, LLC's** Insurance Policies and Payment Policies. I accept all terms of this agreement. This is the agreement in its entirety, and no promises outside of the agreement made on or before the effective date will be binding upon the parties.

Patient/Parent/Guardian Signature

Date

Patient/Parent/Guardian Printed Name



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Insurance Verification

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Patient Insurance Information

Primary Insurance Co. Policy No. Group No.

Subscriber's Name Date of Birth Relationship to patient

Secondary Insurance Co. Policy No. Group No.

Subscriber's Name Date of Birth Relationship to patient

Parent/Guardian Name

Parent/Guardian Signature

Date



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CANCELLATION & NO-SHOW POLICY

Missed Sessions/Cancellation Policy

All patient cancellations require at least **24 hour** notice. Failure to call or be present for an appointment is considered a missed appointment. All patients will be allowed two free cancellations within 24 hours of appointment per year. For each subsequent cancellation, **Sudbury Speech and Language Therapy, LLC** will charge the patient or parent/guardian the rate of a normal visit for all missed appointments. All appointments cancelled with more than 24 hours' notice will accrue no additional charges. Please note that insurance providers do NOT reimburse for missed appointment charges. If the patient misses three or more consecutive therapy sessions, **Sudbury Speech and Language Therapy, LLC** reserves the right to place the patient's services on hold until scheduling conflicts are resolved. Please help us serve you better by keeping scheduled appointments or calling at least 24 hours prior to reschedule. If we are unable to keep a therapy appointment for any reason, we will notify you as soon as possible and a make-up appointment will be scheduled.

Illness Policy

If the patient has a fever, a persistent cough, or a runny nose, please call and cancel your appointment. **Sudbury Speech and Language Therapy, LLC** reserves the right to take a patient's temperature and/or send a patient home if he/she is sick. We appreciate your understanding and will be happy to reschedule your appointment. We have a 24-hour answering service, so feel free to call us at any hour and leave a message.

Inclement Weather Policy

Sudbury Speech and Language Therapy, LLC recognizes the fact that inclement weather and other emergencies can affect one's ability to get to his or her therapy appointment. The safety of our patients is paramount in any emergency. Given that **Sudbury Speech and Language Therapy, LLC's** office is located within a home, the office will remain open even during inclement weather. The patient may use his or her own discretion as to whether they feel able to come in for his or her scheduled therapy appointment. If Sudbury Public Schools have closed that day, there will not be a late cancel charge applied if a patient decides to cancel his or her appointment. If Sudbury Public Schools are open that day and a patient decides to cancel his or her appointment, the typical late cancel charges will be applied.

I have read and accept all policies pertaining to missed appointments, illness, and inclement weather.

Patient/Parent/Guardian Signature

Date

Patient/Parent/Guardian Printed Name



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PERMISSION TO SCREEN, EVALUATE AND/OR PROVIDE THERAPY

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____

Please complete the form below to grant permission and authorize a screening, comprehensive speech and language evaluation, and/or treatment (as needed) for yourself or your child. Speech-language evaluations consist of standardized testing, informal and formal observations, and clinical judgment.

I, _____ (Client/Parent/Guardian), authorize **Sudbury Speech and Language Therapy, LLC** to screen, evaluate and/or provide the necessary speech and/or language treatment/therapy/services to _____ (Patient). Treatment is based upon the findings of the evaluation and the recommendations of the responsible speech-language pathologist.

Patient/Parent/Guardian Signature

Date

Patient/Parent/Guardian Printed Name

You will be contacted regarding the results of the screening. A complete evaluation and/or subsequent treatment will only be administered after your therapist has spoken with you about the results of the screening and fees. You will be asked whether you would like the patient to receive a comprehensive evaluation and if an evaluation is agreed upon, a state-licensed and nationally certified speech-language pathologist will administer the evaluation (including standardized evaluation tests, language samples, caregiver interviews, etc.). Your therapist will provide subsequent treatment, if needed, to the aforementioned patient. Results of the evaluation will determine a treatment/therapy course that will include the recommendations of the speech-language pathologist and input from the parent. Goals can be established through one or more of the following means: administered evaluations/reports, outside evaluations/reports, observations, and parent requests.



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CONSENT FOR RELEASE OF INFORMATION

Patient's Name: _____

Date of Birth: _____

I, _____ (Patient/Parent/Guardian) hereby grant **Sudbury Speech and Language Therapy, LLC** to communicate with the following person or agency:

Physician Name: _____

Address: _____

Phone: _____

Fax: _____

OTHER COMMUNICATION AUTHORIZATIONS: (If you would like us to communicate with any other professional/ person regarding your child's communication skills, i.e., physical therapist, occupational therapist, etc...)

Name: _____

Occupation: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Name: _____

Occupation: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Parent/Guardian Name

Date

Parent/Guardian Signature



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PATIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA AUTHORIZATION) HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

YOUR PRIVACY RIGHTS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Sudbury Speech and Language Therapy, LLC** is dedicated to ensuring the privacy of you or your child's speech and/or language evaluation findings and course of therapy treatment. In serving our patients, we create records regarding treatment and services that are provided in order to have accurate information and ensure the appropriateness and efficiency of treatment services. Federal law requires us to strictly protect any personally identifying information on you or your child. This notice discloses our policies regarding the storage, use, and sharing of confidential patient information. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

Sudbury Speech and Language Therapy, LLC is required by law to keep your health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history
- Your test results
- Treatment notes
- Insurance information

A government rule requires that you get a copy of this privacy notice. This rule is called the Health Insurance Portability and Accountability Act, or HIPPA for short. We will ask you to sign a paper acknowledging that you have been given this notice.

How Your Health Information May Be Used or Shared

We may use your health information without your permission for the following reasons:

1. **Treatment:** We may share your information with doctors or other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.
2. **Payment:** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for therapy services. This may include sharing important medical information. We may share information to:
 - a. Get the insurance company's permission to start treatment
 - b. Get permission for more treatment
 - c. Get paid for the treatment you receive
3. **Health Care Operations:** We may use and share your health information to run the clinic and make sure all patients receive good care. For example, we may use your health information to:
 - a. See how well our services are working
 - b. See how well our staff is doing
 - c. See how we compare to other clinics and private practices
 - d. Make our services better
 - e. Help others study health care services

Your health information may also be used or shared without your permission for:

- **Abuse and Neglect:** We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders:** We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by email, or by phone call or voicemail message. If you do not wish to get reminders, please tell your speech-language pathologist.
- **As Required by Law:** We will share your information when we are told to by federal, state or local law. We will also share information if we are asked by the police or courts.



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- **Government Functions:** Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- **Information About a Person Who Has Died:** We may share information with the coroner, medical examiner, or a funeral director, as needed.
- **Health-Related Benefits and Services:** We may use your information to let you know of other services that might be of interest to you.
- **Public Health Risks:** We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
- **Regulatory Oversight:** We may use or share your information to report to agencies overseeing health care. This may include sharing information for audits, licensure and inspections.
- **Threats to Health and Safety:** Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others.
- **Worker's Compensation:** We will share your information with Worker's Compensation if your case is being considered as a work-related injury.

When Your Permission is Needed to Use or Share Your Health Information

You must give us your permission to use or share your health information for any situation that is not listed on this notice. You will be asked to sign a form, called an authorization, to allow us to share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

Your Privacy Rights

You have the right to:

- **Ask us not to share your information:** You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately:** You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call you but not email. Or you may want us to call you at work and not at home. You must ask in writing.
- **Look at and copy your health information:** You have the right to see your health information and get a copy of that information at any time. You have the right to see treatment, medical and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- **Ask for changes to your health information:** You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your information was used or shared:** You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this:
 - You need to ask us in writing.
 - You must tell us the dates you are asking about and if you want a paper or electronic copy.
 - You may get information going back six (6) years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.
- **Get a paper copy of this privacy notice:** You can get a paper copy of this notice at any time.
- **File complaints:** You can file a complaint with us or with the government if you think that:
 - Your information was used or shared in a way that is not allowed
 - You were not allowed to look at or copy your information



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- Any of your rights were denied

Who is Covered by This Notice

The people that must follow the rules of this notice are:

- All speech-language pathologists at Sudbury Speech and Language Therapy, LLC.
- Anyone who is allowed to add health information to your file, including students and other staff
- Any volunteers who may help you while you are at this clinic/private practice

Changes to the Information in This Notice

We may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Complaints

You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts

If you have any other questions about this notice or your privacy rights, please ask your speech-language pathologist.

I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES DISCLOSED IN THIS NOTICE.

Patient/Parent/Guardian's Signature

Date



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Acknowledgement That You Received Your Privacy Notice

Sudbury Speech and Language Therapy, LLC is required by law to keep your health information safe. This information may include:

- Notes from your doctor
- Your medical history
- Your test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of your privacy notice. Please retain a copy of this privacy notice for your records. This notice tells you how your health information may be used or shared. It also tells you how you can look at and comment on your information.

By signing this page, you are acknowledging that you have been given a copy of our privacy notice.

Patient Name

Patient Date of Birth

Parent Name (if patient is under 18 years)

Patient/Parent/Guardian Signature

Date



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CASE HISTORY FORM

IDENTIFYING AND FAMILY INFORMATION

Name of Person Completing this Form				Relationship to Patient	
Name of Patient		Gender		Date of Birth	
Address				Home Phone	
City	State	ZIP	Cell Phone		
Email Address				Work Phone	
Mother's Name			History of Speech Delay		
Father's Name			History of Speech Delay		
Additional Family History Information Relevant to Speech/Language Disorders					
		Y _____ N _____			
Languages Other Than English Spoken in Home		Does Child Speak the Language?		Which Language does Child Prefer to Speak at Home?	
Physician / Pediatrician				Phone	
Address				City	State

MEDICAL HISTORY

Has your child had any of the following? Please check ALL that apply:

☐	Adenoidectomy	
☐	Allergies:	
☐	Head Injury	
☐	Tonsillitis	Frequency:
☐	Tonsillectomy	
☐	Other Serious Injury / Surgery:	

Hearing

☐	Ear Infections	Frequency:
☐	Otological Care	Surgery:
Date of Last Hearing Screening:		



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Other Hearing Concerns

Vision

Impairments or concerns about vision:

BIRTH HISTORY / DEVELOPMENTAL HISTORY

Mother's health
during pregnancy:

Yes

No

Was child born premature:

If yes, how many weeks:

Did child spend time in the NICU

If yes, how long:

Complications
during pregnancy
or delivery:

Developmental milestones
achieved within normal limits:

If no, please explain:

SPEECH DEVELOPMENT

Age of first word spoken:

When did you first become concerned about child's speech:

Do you have a family history of speech delays? If so, please explain:

Does your child:

Repeat sounds, words or phrases over and over?

Understand what you are saying?

Retrieve / point to common objects upon request (ball, cup, shoe)?

Follow simple directions ("shut the door" or "get your shoes")?

Respond correctly to yes/no questions?

Respond correctly to who/what/where/when/why questions?

How does your child communicate with you?



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Please list previous speech-language evaluations. Please include the date of the evaluation, who conducted it, and the results. Please provide a copy, if available.

Does your child take any medication? If so, please list the medication and explain if and/or how these medications affect his/her behavior

Medical or School Determined Diagnoses: (Please explain & include date of diagnosis:

Please list other comments/concerns about your child's speech:

SCHOOL/ACTIVITIES

Name of School

School Address

City

State

How long has your child been enrolled?

Present grade level:

Does your child receive any special services (including speech therapy, occupational therapy, physical therapy, etc...)?

By signing below, I certify that the information provided above is accurate and correct to the best of my knowledge.

Parent/Guardian Name

Date

Parent/Guardian Signature



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Authorization for Credit Card Use (Voluntary)

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

Credit Card Type: Visa Mastercard Discover Amex

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

I authorize Sudbury Speech and Language Therapy, LLC to charge the balance amount due to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

Return the completed and signed form via email to: info@sudburyspeech.com or mail to:

**Sudbury Speech and Language Therapy
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