Welcome to Speech Therapy Solutions!

Thank you for choosing Speech Therapy Solutions to help your child achieve his/her speech-language and/or feeding goals. We realize that you have options regarding speech therapy for your child and we are happy you selected us to assist your child in achieving these goals!

The new patient paperwork packet includes important information about the therapeutic process including financial, attendance, and privacy policies. Please take time to fill out the necessary forms completely as possible to enable the most accurate treatment plan. Additionally, if your child has had any recent assessments completed by other health care professionals including but not limited to an Audiologist, ENT, etc. please provide copies so that we are able to get the whole picture of your child.

Completed form packets along with a copy of your insurance card may be brought to the initial visit, emailed to Lisa@speech-ts.com, or mailed to 620 Dr. Calvin Jones Highway, Suite 200 Wake Forest, NC 27587.

We look forward to working with you and your child!

Sincerely,

Natalie Parker, MA, CCC/SLP
Licensed Speech-Language Pathologist/Co-Owner
Speech Therapy Solutions

Lisa W. Pridgen, M Ed, CCC/SLP
Licensed Speech-Language Pathologist/Co-Owner
Speech Therapy Solutions

General Information and FAQs

Is speech therapy covered by my insurance company?
Insurance coverage varies greatly depending on your individual plan. It is your responsibility to contact your insurance company prior to your first visit to verify coverage.

When will I receive a bill?
Therapy sessions are billed the week following your visit and allowed one month to process, troubleshoot, refile, etc. Invoices are emailed (or mailed at your request) on a monthly basis. For example, an invoice for January sessions would be emailed out March 1 and be due March 20. Most private insurance companies conduct random audits of therapy sessions and this may delay claim processing. Therapists are NOT permitted to accept payments. Please make your payment via the email invoice or mail your payments to our office: 620 Dr. Calvin Jones Highway, Suite 200 Wake Forest, NC 27587.

Do you conduct in home assessments and treatment?
This will be determined on an individual basis. If you are participating in the Infant-Toddler Program your treatment sessions will be conducted in home, daycare, preschool (not office).

What are your hours of operation?
We try to accommodate all of our busy families by offering flexible hours by appointment. Our typical days/times of appointments include Monday – Thursday 8:00 – 4:00.

How long do your assessments and therapy sessions typically last?
Comprehensive assessments typically last 45 minutes - 1 hour and are performed during 1 visit. All assessments are highly individualized and are dependent on the child's unique needs. Therapy session duration is dependent on each individual child and typically last 30 minutes.

PERMISSION TO EVALUATE AND TREAT / INSURANCE AGREEMENT

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ TELEPHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Email:_____ *How do you prefer to communicate? ☐Email ☐Text ☐Call

MEDICAID #:	LAST WELL-CHILD CHECK UP:
PRIMARY CARE PRACTICE & PHYSICIAN:	PHONE: FAX:

PRIMARY POLICY:	☐ INDIVIDUAL ☐ GROUP ☐ HMO/PPO
INSURANCE NAME:	
EMPLOYER/GROUP:	
POLICY/ID #:	
GROUP ID:	
EFFECTIVE DATE:	
CLAIMS ADDRESS:	
SUBSRIBER'S NAME:	
RELATIONSHIP TO PT:	☐ SELF ☐ CHILD ☐ OTHER
SUBCRIBER'S DOB:	
SUBSCRIBER'S ADDRESS:	

INITIAL:

_____ I give permission for my child, _____, to receive a speech-language evaluation and /or treatment as indicated in his/her Plan of Care.

_____ The insurance information on record for my child is current and accurate. I understand that if my child is covered by private insurance and Medicaid, private insurance must be billed first under Medicaid Policy, before Medicaid benefits can be assessed. I consent for Speech Therapy Solutions to bill the private insurance and / or Medicaid on record for my child for <u>all</u> speech therapy services. I authorize the release of medical or clinical information necessary to process the insurance claim.

_____ I understand it is the insurance policy holder's responsibility to be familiar with their speech therapy benefits with their insurance company and assume responsibility for payment of services not paid for by insurance.

_____ _____

Parent/Guardian Signature Date

620 Dr. Calvin Jones Highway, Suite 200 Wake Forest, NC 27587
919-219-5277 * Fax 919-573-0478 * natalie@speech-ts.com * www.speech-ts.com

SPEECH THERAPY SOLUTIONS

ATTENDANCE AND CANCELLATION POLICY

Your therapist reserves an appointment time specifically for your child. Please make every effort to make this appointment. In the event that you are unable to make your scheduled appointment, we require at least **24 hour** notice so we are able to offer the appointment time to another family in need. In the event of frequent cancellations/missed appointments, we will need to reconsider our ability to offer you a regularly scheduled appointment time as we have other families on our wait list. We understand that events and illness can occur unexpectedly and will take that into consideration before discharging.

IMPORTANT!

Often payer sources (Medicaid, private insurance, etc) require evidence of consistent therapy and progress before approving ongoing treatment. Therefore, therapists are REQUIRED to makeup all missed appointments.

If you are unable to keep your appointment or need to reschedule, please call us at least 24 hours prior to your appointment.

How to Cancel Your Appointment:

To cancel appointments, please call/text your therapist or our office at (919) 219-5277. If you do not reach the therapist or office, please leave a message on the voice mail. You may also email natalie@speech-ts.com or use the "contact us" tab on our website.

_____ _____

Parent/Guardian's Signature Date

_____ _____

Parent/Guardian's Printed Name Child's Name (printed)

620 Dr. Calvin Jones Highway, Suite 200 Wake Forest, NC 27587
919-219-5277 * Fax 919-573-0478 * natalie@speech-ts.com * www.speech-ts.com

PATIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA AUTHORIZATION)

I hereby authorize use or disclosure of protected health information about my child as described below:

1. Confidential information is stored in a secure location away from public access. All computers and PDA's containing confidential information are only accessed by password.
2. Speech Therapy Solutions, PLLC is authorized to disclose pertinent health information to insurance companies or referring physicians for the purposes of requesting doctor's orders, authorization for service, or to obtain reimbursement for services. Information may be sent via first class mail or fax with procedures in place to limit the likelihood of unauthorized access. The date sent will be documented by the responsible office personal.
3. Speech Therapy Solutions, PLLC and its employees are authorized to use or disclose pertinent health information that is required for speech-language therapy purposes.
4. Speech Therapy Solutions, PLLC may disclose protected health information considered pertinent to speech-language therapy to specified professionals (i.e. social workers, teachers, psychologists, physicians, therapists, etc.) with a signed release form from parent or guardian.
5. I, the parent/guardian, understand that all employees of Speech Therapy Solutions, PLLC are given a copy of the Privacy Policy Procedures, sign a confidentiality agreement, and will only have access to information required to complete their job responsibilities.
6. I, the parent/guardian, may revoke this authorization by notifying Speech Therapy Solutions, PLLC in writing of my desire to revoke it. However, I understand that any action already completed prior to the request to revoke this authorization cannot be reversed, and my revocation will not affect those actions.
7. This authorization expires when the client is discharged from therapy, although the Company will always use professional discretion when sharing any PHI.

_____ _____

Parent/Guardian's Signature Date

_____ _____

Parent/Guardian's Printed Name Child's Name (printed)

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CONSENT FOR RELEASE OF INFORMATION

Child's Name: _____ Date of Birth: _____

I authorize the release of information including, but not limited to: evaluation reports, treatment plans, progress notes and therapy documentation, as well as necessary verbal communication pertaining to my child.

FROM:

Speech Therapy Solution, PLLC
Dr. Calvin Jones Highway, Suite 200
Wake Forest, NC 27587
Phone: (919) 219-5277
Fax: (919) 573-0478

TO:

☐ Physician:
_____

☐ School SLP:
_____

☐ CDSA:
_____

☐ Other:
_____

☐ Other:
_____

Authorization for the Release of Information is good for the length of time that the above named patient is under the care of Speech Therapy Solutions unless otherwise terminated by patient or legal guardian (requests for termination of this agreement must be made in writing).

_____ _____
Parent/Guardian Signature Date