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 includes important information about the therapeutic process including financial, attendance, and privacy policies. Please take time to fill out the necessary forms completely 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 electronically signed here, printed and brought to the initial visit, or emailed to natalie@speech-ts.com.

Upon completion of the welcome packet paperwork, we can confirm your appointment. Please be aware of if you are scheduled in the **Wake Forest Office, Heritage Office, Raleigh office or Garner office.**

Wake Forest Office
616 Dr. Calvin Jones Hwy., Suite 212
Wake Forest, NC 27587

Heritage Office
1764 Heritage Center Dr., Suite 202
Wake Forest, NC 27587

Raleigh Office
6512 Six Forks Rd., Suite 401a/b
Raleigh, NC 27615

Garner Office
649 Poole Dr.
Garner, NC 27549

There is no need to arrive early to your appointment. When you arrive, please check in at the iPad in front. Select your therapist's name and enter your child's name. Your therapist will come out and get you in the waiting room at your appointment time. Parents are welcome to join in the session, wait in the waiting room or wait in their car if you stay on the premises.

We look forward to working with you and your child!

Sincerely,

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

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

SPEECHTHERAPY SOLUTIONS

PERMISSION TO EVALUATE AND TREAT / INSURANCE AGREEMENT

PATIENT NAME:	GENDER:	DATE OF BIRTH:
ADDRESS:	CITY:	ZIP:
PHONE:	EMAIL:	
CAREGIVER COMPLETING FORM:		RELATIONSHIP:
PRIMARY CARE PHYSICIAN:	PRACTICE:	LOCATION:
PRIMARY INSURANCE: Please include **suffix** if applicable and email a picture of the insurance card front and back. Incomplete insurance sections will be returned for completion.		
POLICY/ID #:		GROUP ID #:
SUBSRIBER'S NAME:		SUBCRIBER'S DOB:
MEDICAID #:	LAST WELL-CHILD CHECK UP:	

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

_____ 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 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

_____

Parent/Guardian's Printed Name

616 Dr Calvin Jones Hwy, Ste 212 Wake Forest, NC 27587
1764 Heritage Center Dr, Ste 202 Wake Forest, NC 27587
6512 Six Forks Rd, Ste 401a/b Raleigh, NC 27615
649 Poole Dr., Garner, NC 27529
919-219-5277 * Fax 919-573-0478 * natalie@speech-ts.com * www.speech-ts.com

ATTENDANCE AND CANCELLATION POLICY

Your therapist reserves an appointment time specifically for your child. Please make every effort to make this appointment. If 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 discharge. A $50 no show fee will be charged for missed appointments to any patient not enrolled in Medicaid.

IMPORTANT!

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

Frequent cancelations and/or 2 no shows will result in discharge from services.

How to Cancel Your Appointment:

To cancel appointments, please call/text your therapist directly. If you do not reach your therapist or office, please leave a message on voicemail.

Payments:

A service fee of 1.5% will be added to your bill every month for all OVERDUE payments. You may set up a payment plan or sign up for automated payments to be billed at your convenience. Late fees and no-show fees are NOT billable to insurance. Inquire to Lisa@speech-ts.com.

_____ _____

Parent/Guardian's Signature Date

_____ _____

Parent/Guardian's Printed Name Child's Printed Name

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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 office personnel responsible.
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 Printed Name

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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. Please fill in your selections.

TO/FROM:

Speech Therapy Solution, PLLC
616 Dr Calvin Jones Hwy, Suite 212
Wake Forest, NC 27587
Phone: (919) 219-5277
Fax: (919) 573-0478

TO/FROMS:

☐ Physician:

_____

☐ School SLP:

_____

☐ CDSA:

_____

☐ 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

SPEECHTHERAPY SOLUTIONS

CASE HISTORY

1. **What concerns do you have regarding your child's speech and/or feeding skills?**

2. **Have you been treated for speech and/or feeding before? If so, when/where?**

3. **Any significant birth or medical history?**

4. **Please list any concerns you may have with fine/gross motor skills or sensory processing?** (For example: difficulty with textures or fabrics, picky eating, W-sitting, difficulty holding a pencil, avoiding messy play, sensitivity to noise or lights, difficulty with transitions)

Parent/Guardian's Signature

Date

Parent/Guardian's Printed Name

Child's Printed Name

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