Welcome to Liberty Speech Associates LLC! Thank you for selecting our office for your speech and language needs. Our goal is to provide you and your family with quality, research-based speech-language pathology services. We strive to promote the effective and functional communication skills of our clients by providing services in a natural environment.

Enclosed in this packet, you will find the following forms:

- Adult Intake Form
- Policies and Procedures
- Communication Preference Form
- Insurance Form
- Acknowledgement of HIPAA Privacy Notice
- HIPAA Policy

If you have any questions, please feel free to contact us by phone or email. We are looking forward to working with you.

Please sign below to acknowledge the following:

□ You have read all of the forms and documents provided to you in connection with evaluation and treatment provided by Liberty Speech Associates LLC, their employees, and/or contractors.

□ You understand the meaning and intent of the provided forms and agree to all content included.

□ You have been given an opportunity to ask questions about the provided forms and all questions you've asked have been answered to your satisfaction by Liberty Speech Associates LLC.

____________________________________ ____________________
Print Name of Client Date

____________________________________ ____________________
Signature of Client or Legal Representative Relationship to Client

Adult Intake Form

Name: ____________________

Date of Birth: ____________ Age: ______ Sex: Male ☐ Female ☐

Address: ____________________

City: ____________ State: ______ Zip: ______

Home Phone: ____________________

Cell Phone: ____________________

Work Phone: ____________________

E-mail: ____________________

Race/Ethnicity (select one or more):

☐ American Indian/Alaskan Indian ☐ Asian

☐ Black/African American ☐ Hispanic/Latino

☐ Native Hawaiian or Other Pacific Islander ☐ White

Emergency Contact:

Name: ____________________

Phone Number: ____________________

Is this number for ☐ Home ☐ Cell ☐ Work

Relationship to Client: ____________________

Referral Source:

☐ Doctor ☐ School ☐ Counselor/Therapist ☐ Friend ☐ Self ☐ Other

Reason for Visit

____

____

____

Have you received speech-language pathology services before? ☐ Yes ☐ No

If yes, when? ____________________

Where? ____________________

Medical History:

List illnesses, surgeries, injuries, or medical problems:

____

____

List medications taken on a regular basis:

____

____

List known allergies:

____

____

Have you had problems with or changes in (check all that apply):

- ☐ Hearing:
  - Wear hearing aid(s)? ☐ Yes ☐ No
  - Had hearing test? ☐ Yes ☐ No
  - If yes, when? ______________________________
- ☐ Vision:
  - Wear glasses? ☐ Yes ☐ No
  - Wear corrective lenses? ☐ Yes ☐ No
  - Had vision screened? ☐ Yes ☐ No
  - If yes, when? ______________________________
- ☐ Teeth:
  - Wear dentures? ☐ Yes ☐ No
- ☐ Breathing:
- ☐ Swallowing:

Education and Work History

Last grade completed: ______________________________

Occupation: ______________________________

Currently working? ☐ Yes ☐ No

Recreational Activities: ______________________________

Language(s) Spoken

Is English your primary language? ☐ Yes ☐ No

If no, is an interpreter needed? ☐ Yes ☐ No

If no, what language(s) is/are spoken at home:

___

If no, what language(s) is/are spoken in your workplace/community:

___

Additional Information

Is there anything else you'd like for us to know about you?

___

___

___

Client Name

___

Signature of Client or Legal Representative

___

Relationship to Client

___

Date

Policies and Procedures

Please carefully review the policies and procedures outlined below:

Illness: It is not beneficial for you to participate in therapy or evaluations when you are ill or contagious. For that reason, sessions should be canceled under the following circumstances:

- ❑ If you have had a fever, have been vomiting, or have had diarrhea in the past 24 hours,
- ❑ If you have a rash, and/or
- ❑ If anyone in the household has lice or flu-like symptoms.

Holiday Closings: Our office will be closed on all major holidays. For a complete list of holiday closings, please contact us.

Weather: In the event of inclement weather, you will be notified prior to your appointment if the session is going to be canceled.

Fees & Payment: A complete fee schedule is available upon request. All relevant fees will be discussed prior to initiating a service. Fees apply to various types of services including direct client contact (therapy sessions and evaluations), phone consultations, and consultation with other professionals. Payment for direct client contact is expected at the time of service. You will receive a bill in the mail for consultative services. Payment can be in the form of credit card, as well as cash or checks made payable to Liberty Speech Associates LLC. A $25 service charge will be required for any returned checks.

If you are using a third-party payer (e.g., insurance company) for speech therapy and/or evaluation coverage, you understand that you are responsible for all costs / fees that the third-party payer does not cover. In the event that a third-party payer source determines that rendered therapy services are "not covered" or otherwise denied, you will be responsible for all outstanding charges. You will be billed accordingly and will be responsible for immediate payment. Liberty Speech Associates LLC will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial. If fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received. Charges incurred and not paid after 30 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau. You are responsible for all legal and collection fees, which Liberty Speech Associates LLC may incur if payment is not made in accordance with the terms and conditions herein.

Refunds will be issued only in instances of overpayment. All refunds will be processed within 1 week after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds will be issued by check.

Insurance:
In-Network: We are currently in-network with *Horizon Blue Cross Blue Shield of NJ*, *Highmark Blue Shield*, and *Medicare Part B*. If you have one of these insurances, we will submit claims on your behalf. Please be advised that in-network participation does not guarantee coverage for your speech and language services. You are responsible for any applicable copays, coinsurances, deductibles, and/or unpaid claims.
Out-of-Network: We are considered out-of-network with any insurance not listed above. If you are a member of a non-participating insurance company, our office can supply you with a monthly invoice detailing the services that were rendered so that you may submit it to your insurance company in an effort to obtain reimbursement. Please keep in mind that, depending on your insurance company, you may not receive reimbursement for speech and language services. If you are interested in receiving monthly invoices, please notify our office.

Additional Information: To learn more about insurance coverage, please read the attached article "9 Questions to Ask Your Insurance Company about Speech Therapy Coverage."

Attendance: Attendance and participation in therapy along with complete compliance with any associated home programs are essential for therapeutic success. While we understand that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows." Please contact your assigned speech-language pathologist at least two business days prior to your appointment for any non-emergency cancellations including, but not limited to, vacations, preplanned doctor's appointments, extracurricular activities, and family events. If the appointment is cancelled in less than two business days, you will be billed the full evaluation or session fee. Please be advised that third-party payers do not cover cancellation fees. If you cancel or do not attend 3 consecutive appointments, we will put your services on hold until scheduling problems can be worked out.

Late for Appointments: You must be present and available to start the speech therapy session and/or evaluation at your scheduled appointment time. The speech-language pathologist will wait up to 10 minutes for you to be available, so that the appointment can begin. If you are up to 10 minutes late for your appointment, we will deduct that time from the allotted session time (e.g., If you are scheduled for a 30-minute session to begin at 10:00 am, but you are late and the session does not begin until 10:10 am, you will only receive a 20-minute session that day). Please be aware that if the appointment begins late because you were not present or available, you will still be billed the cost of a complete appointment. If you are late for 3 or more sessions, we may put your services on hold until scheduling problems can be worked out. If you are more than 10 minutes late for your appointment, we reserve the right to cancel the appointment and consider it a no show. You will be billed the full evaluation or session fee for a no show. Please understand that third-party payers do not cover no show fees.

Clinician Cancellations: If your speech-language pathologist is not able to attend your appointment (due to illness, emergency, etc.), you will be contacted as soon as possible. You will be given advance notice of the speech-language pathologist's vacations. Please be sure that your speech-language pathologist knows the best way to reach you.

Make-Up Sessions: Make-up sessions may be offered for the family's non-emergency and emergency cancellations when ample notice is given and our cancellation policy is met. Make-up sessions may also be offered for the speech-language pathologist's cancellations when the cancellations are the result of illness, emergency, or business-related obligations (e.g., attending or presenting at conferences). Makeup sessions will not be offered for the speech-language pathologist's pre-scheduled vacations, unless two consecutive weeks of therapy are missed.

Services:

Therapy

Therapy sessions vary in length depending on the client's needs. The last few minutes of each session will be spent discussing the session with you and/or your caregivers, providing home practice activities, and writing notes about treatment. If you require additional time to discuss your treatment, please contact our office to schedule a phone consultation or in-person conference. The consultation/conference will be billed at the current hourly rate (prorated).

Evaluations

Evaluation appointments are scheduled for up to 2 hours. If additional time is needed to conduct a complete and thorough evaluation, time will be billed based upon the current hourly rate (prorated). After the evaluation has been completed, you will receive a diagnostic report detailing your performance during the evaluation, as well as relevant recommendations.

Privacy and Confidentiality: We respect your privacy and confidentiality. Email, text messages, and direct messages on Facebook and other social media platforms are insecure methods of transmitting and discussing confidential information. If you would like to discuss your treatment or evaluation, it is best that you schedule a phone consultation or in-person conference. Treatment or evaluation results can be discussed with relevant others (e.g., employer, healthcare professional) upon request. If you would like us to discuss or share your treatment or evaluation results with an employer, agency, or family member, please complete an Authorization to Exchange Information.

Termination of Services: You may terminate your therapy by phone, email, or in person at any time for any reason.

Changes in Policy: Changes to this policy may be made at any time. You will be notified of any policy changes before they take effect.

☐ I agree to the policies and procedures outlined above.

______________________________	______________________
Print Name of Client	Date
______________________________	______________________
Signature of Client or Legal Representative	Relationship to Client

Communication Preference Form

Primary Contact Person: ______________________________

Relationship to Client: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: ______________________________

Email: ______________________________

In an effort to ensure your privacy, it is important for us to understand your preferred contact method(s). As such, please indicate your communication preferences below.

Clinical Information
For clinical information, such as clinical documentation, diagnostic reports, therapy updates, etc., I hereby grant permission to Liberty Speech Associates LLC, their employees, and/or their contractors to do the following (select all that apply):

□ I grant permission to provide me with written communication via unencrypted email service at the email address provided. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

□ I grant permission to leave relevant clinical information on my answering machine or voicemail at the following number: ______________________________.

□ I grant permission to provide me with written communication via USPS to the address provided.

□ I elect to receive clinical information in person.

Appointment Information
For appointment information, such as appointment reminders, schedule changes, cancellations, etc., I hereby grant permission to Liberty Associates LLC, their employees, and/or their contractors to notify me by: □Call □Text □Email

I understand that Liberty Speech Associates LLC, their employees, and/or their contractors will use the preferred contact method(s) chosen above for appointment and clinical information. I also understand that it is my responsibility to inform the practice of any changes to this information or to my communication preferences.

______________________________ ______________________
Print Name of Client Date

______________________________ ______________________
Signature of Client or Legal Representative Relationship to Client

Insurance Form

Responsible Party:
Name: ______________________________ DOB:________ ☐ M ☐ F
Address: ____
City/State: ______________________________ Zip: __________
Home Phone: ( ) ______________
Employer: ____
Address: ____
City/State: ______________________________ Zip: __________
Work Phone: ( ) ______________

Insurance Information
Please provide a copy of your insurance card and license with this form.

Primary:
Insurance Co.: ______________________ Phone: ( ) ____________
Policy Holder: ____
Date of Birth: ______________ SSN: _________________________
ID/Policy #: ____
Group #: ___________________ Group Name: ___________________

Secondary:
Insurance Co.: ______________________ Phone: ( ) ____________
Policy Holder: ____
Date of Birth: ______________ SSN: _________________________
ID/Policy #: ____
Group #: ___________________ Group Name: ___________________

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) related to any and all health benefits due to my dependents and me.

I also authorize payment of healthcare benefits otherwise payable to me, directly to Liberty Speech Associates LLC. I agree to be held responsible for all charges and services not paid by my insurance company.

______________________________ ________________
Print Name of Client Date

______________________________ ________________
Signature of Client or Legal Representative Relationship to Client

Acknowledgement of HIPAA Privacy Notice

Liberty Speech Associates LLC is required by law to keep your health information and records safe. This information may include:

Notes from your doctor, teacher or other healthcare provider
Medical history
Test results
Treatment notes
Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

□ I acknowledge that I have received a copy of Liberty Speech Associates LLC's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

□ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

□ I understand that Liberty Speech Associates LLC cannot disclose my health information other than as specified in the notice.

□ I understand that Liberty Speech Associates LLC reserves the right to change the notice and the practices detailed therein if I receive a copy of the revised notice to the address I have provided.

________________________________	____________________
Print Name of Client	Date
________________________________	____________________
Signature of Client or Legal Representative	Relationship to Client

HIPAA POLICY
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of January 1, 2019 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775