Liberty Speech Associates

Welcome to Liberty Speech Associates LLC! Thank you for selecting our office for your child's 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.

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

- Pediatric Intake Form
- Policies and Procedures
- Communication Preference Form
- Insurance Form
- Good Faith Estimate & Fee Schedule
- Authorization for Student Participation
- 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.

_____ _____

Name of Client* Date*

_____ _____

Name of Parent or Legal Representative* Relationship to Client*

_____

Signature of Parent or Legal Representative*

Pediatric Intake Form

Client Name: _____

Date of Birth: _____ Age: _____

Address: _____

_____

Person Completing This Form: _____

Relationship to Client: _____

Parent 1 Name: _____

Parent 1 Address: _____

_____

Parent 1 Occupation: _____

Parent 1 Employer: _____

Parent 1 Education Completed: _____

Parent 1 Language(s) Spoken: _____

Parent 2 Name: _____

Parent 2 Address: _____

_____

Parent 2 Occupation: _____

Parent 2 Employer: _____

Parent 2 Education Completed: _____

Parent 2 Language(s) Spoken: _____

List all children in the family from oldest to youngest:

Name	Age	Grade	Sex	Communication and/or Learning Challenges
				□Y □N
				□Y □N
				□Y □N
				□Y □N
				□Y □N

Birth History

Child's weight at birth: _____

Was the child full term? □Y □N

Were there any unusual factors relating to the pregnancy (e.g., X-ray treatments, RH negative, drugs or medications, previous miscarriages)? □Y □N

If yes, please describe: _____

_____

Type of birth: □Normal □Induced □Forceps □Caesarean □Premature □Other

If other, please describe: _____

_____

If premature, how many weeks: _____

Were there any physical deformities or malformations observed at birth (such as "blueness," jaundice, abnormal shape of head)? □Y □N

If yes, please describe: _____

_____

Medical History

Date of last medical examination: _____

Type of medical examination: _____

Child's pediatrician or family doctor: _____

Doctor's address: _____

Other doctor(s) treating your child: _____

_____

Has the child had any previous testing or therapy for speech or language problems? □Y □N

If yes, please describe: _____

_____

Please explain why you are currently seeking an evaluation: _____

_____

_____

List ages for any of the following childhood diseases:

	Age	Complications
Whooping cough		□Y □N
Mumps		□Y □N
Measles		□Y □N
Rheumatic fever		□Y □N
RSV		□Y □N
Pneumonia		□Y □N
Chicken Pox		□Y □N
Tonsillitis		□Y □N
Other		□Y □N

If other, please describe: _____

_____

Please describe any complications from any of the aforementioned diseases:

_____

_____

_____

Is the child subject to frequent colds and/or sore throats? □ Y □ N

Does the child have allergies and/or hay fever? □ Y □ N

If yes, please describe: _____

_____

Has the child had their tonsils and/or adenoids removed? □ Y □ N

If yes, please describe: _____

_____

Has the child had any of the following ear troubles (select all that apply)?

□ ear infections
□ earaches
□ ear fluid and/or drainage
□ diagnosed hearing loss
□ suspected hearing loss
□ other

If other, please describe: _____

_____

Has the child ever had ear (PE) tubes? □ Y □ N

If yes, when: _____

If yes, are the tubes still in? □ Y □ N

Has the child had any vision problems? □ Y □ N

If yes, please describe: _____

Does the child have any dental problems? □ Y □ N

If yes, please describe: _____

Has the child seen a specialist for any reason? □ Y □ N

If yes, please describe: _____

Developmental History

In early childhood, did the child have any feeding problems? □ Y □ N

If yes, please describe: _____

At what age(s) did the child do the following:

	Age
Sit unsupported	
Eat solid foods	
Crawl	
Stand alone	
Walk	
Self-feed	
Self-dress	
Bladder/bowel control	

Do you feel that the child was late or had difficulty in the development of these behaviors?
□ Y □ N

Communication History

Is the child's speech understandable to any of the following individuals? (select all that apply)

□ Parent(s) □ Other family members □ Friends □ Strangers

List sounds or words that the child has trouble saying: _____

_____

Compared to siblings, the child's communication development is judged to be:

□ Behind □ Same □ Advanced

Does the child use gestures in a meaningful way? □ Yes □ No

Give examples of gestures that the child uses on their own (not ones that are mimicked):

_____

_____

Does the child use words in a meaningful way? □ Yes □ No

Give examples of words or sentences that the child uses on their own (not ones that are repeated after you):

_____

_____

When communicating, which does the child prefer to use:

□ Words □ Gestures □ Both

At what age(s) did the child do the following:

	Age
Babble	
Say 1st word	
Put 2 words together in a sentence (e.g., mama come)	
Put more than 2 words together in a sentence (e.g., come play please)	

Does the child seem to understand directions? □ Yes □ No

Give examples of directions that the child is able to follow on their own:

_____

_____

Education History

Did the child attend preschool? □ Yes □ No

If yes, at what age(s) did the child attend? (select all that apply)
□ 2 □ 3 □ 4 □ 5

At what age did the child attend kindergarten: _____

Current school: _____

School Address: _____

_____

Grade: _____ Teacher's Name: _____

Does the child like school? □ Yes □ No

Does the child like their teacher? □ Yes □ No

Describe the child's strengths in school: _____

_____

_____

Describe the child's weaknesses in school: _____

_____

_____

Does the child attend any special classes at school (e.g., speech, reading, resource room, special education classroom)? □ Yes □ No

If yes, please describe: _____

_____

Daily Behavior

Where does the child usually play? (select all that apply)
□ School □ Home □ Friend's house □ Family member's house

Are there children close to the child's age in the neighborhood? □ Yes □ No

Does the child prefer to play alone? □ Yes □ No □ No preference

Who does the child prefer to play with?
□ Younger children □ Adults
□ Older children □ No preference
□ Same-age children

Does the child have a close friend? □ Yes □ No

What does the child do well? _____

_____

What does the child have trouble doing? _____

_____

What are the most frequent disciple problems with this child? _____

_____

_____

Anything Else

Please include any additional information below that you think is important for us to know:

_____

_____

_____

_____

Consent for Services Form

By signing below, you agree to allow Liberty Speech Associates LLC, their employees, and/or their contractors to provide speech-language pathology services to your child. You consent to all services that are within the scope of speech-language pathology practice as defined by the state(s) of New Jersey and Pennsylvania, as well as the American Speech-Language-Hearing Association. You acknowledge that no guarantee has been made to you as to the result of the evaluation and/or treatment.

_____ _____

Name of Client* Date*

_____ _____

Name of Parent or Legal Representative* Relationship to Client*

_____

Signature of Parent or Legal Representative*

Policies and Procedures Form

Please carefully review the policies and procedures outlined below:

Illness: It is not beneficial for your child to attend in-person therapy or evaluations when s/he is ill or contagious. For that reason, in-person sessions should be canceled under the following circumstances:

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

If your child is receiving teletherapy services, s/he can attend the appointment when s/he has the aforementioned illnesses, so long as s/he is well enough to participate in therapy/evaluation tasks. We will leave this up to the discretion of the family.

Holiday Closings: Our office will be closed on the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas Eve, Christmas Day, and New Year's Eve. Our office will also be closed the week between Christmas and New Year.

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

Payment: 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, 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, private school, etc.) 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 canceled 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.

Insurance:
In-Network: We are currently in-network with *Aetna* 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 child's speech and language services. You are responsible for any applicable copays, coinsurances, deductibles, and/or unpaid claims. Our in-network participation status may change at any time. You will be notified in advance of these changes.

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 receipt detailing the services that were rendered so that you may submit it to your insurance company in an effort to obtain reimbursement. Please note that our rates may be different from your insurance reimbursement rate and reimbursement rates could be lower. Additionally, depending on your insurance coverage, you may not receive reimbursement for speech and language services. We recommend that you check with your insurance carrier for rates and coverage of services. If you are interested in receiving detailed receipts to submit to your insurance company, please notify our office.

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."

Cancellation: Each child is entitled to 2 cancellations for any reason per quarter without penalty. Any additional cancellation must be made up within the same quarter that the cancellation occurred. If the make-up session is not completed within the required timeframe, the family will be charged for the full session fee for the missed appointment (currently $130).
Initial* _____

Our office defines quarters as follows:
January 2 - March 31
April 1 - June 30
July 1 - September 30
October 1 - December 23

No Show: Our office defines a "no show" as an appointment that is canceled without notice, as well as a cancellation made within 30 minutes of the scheduled appointment time. The family will be charged for the full session fee for the no show (currently $130).
Initial* _____

Please be advised that third-party payers do not cover cancellation or no show fees. If you cancel or do not attend 3 consecutive appointments, we will put your child's services on hold until scheduling problems can be worked out.
Initial* _____

Late for Appointments: Your child must be present and available to start the speech therapy session and/or evaluation at their 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 your child is up to 10 minutes late for his/her appointment, we will deduct that time from the allotted session time (e.g., If your child is scheduled for a 30-minute session to begin at 10:00 am, but s/he is late and the session does not begin until 10:10 am, your child will only receive a 20-minute session that day). Please be aware that if the appointment begins late because the family or child was 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 your child is more than 10 minutes late for his/her appointment, we reserve the right to cancel the appointment and consider it a no show. As stated above, a no show incurs a full session charge (currently $130).
Initial* _____

Clinician Cancellations: If your child's 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.

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 the parents/caregivers, providing homework activities, and writing notes about treatment. A parent or designated adult (e.g., family member, teacher, babysitter) must be in the building while services are being provided. If you require additional time to discuss your child's treatment outside of the scheduled therapy appointment, please contact our office to schedule a phone consultation or in-person conference. The consultation/conference will be billed at $100/hour (prorated).

Evaluations

Evaluation appointments vary in length depending on the client's needs. The anticipated length of the appointment time will be discussed prior to the initiation of the appointment. A parent or designated adult (e.g., family member, teacher, babysitter) must be in the building while the evaluation is being conducted. After the evaluation has been completed, you will receive a diagnostic report detailing your child's performance during the evaluation, as well as relevant recommendations. If you need additional time to discuss your child's evaluation beyond the scheduled appointment period, please contact our office to schedule a phone consultation or in-person conference. The consultation/conference will be billed at $100/hour (prorated).

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 child's 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., school, healthcare professional) upon request. If you would like us to discuss or share your child's treatment or evaluation results with a school, agency, or professional, please complete an Authorization to Exchange Information.

Termination of Services: You may terminate your child's 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.*

Name of Client:* _____

Today's Date:* _____

Name of Parent/Legal Guardian:* _____

Signature of Parent/Legal Guardian:* _____

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 pertaining to my child, 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 provide me with written communication via USPS to the address provided.
- ☐ I elect to receive clinician information in person.
- ☐ I grant permission to leave relevant clinical information on my answering machine or voicemail on the home phone number listed above.
- ☐ I grant permission to leave relevant clinical information on my answering machine or voicemail on the work phone number listed above.
- ☐ I grant permission to leave relevant clinical information on my answering machine or voicemail on the cell phone number listed above.

Appointment Information

For appointment information pertaining to my child, 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.

Name of Client:* _____

Today's Date:* _____

Name of Parent/Legal Guardian:* _____

Signature of Parent/Legal Guardian:* _____

Relationship to Client:* _____

Insurance Form

Responsible Party

Name:* _____

DOB:* _____

Address:* _____

Preferred Phone:* _____

Employer:* _____

Address: _____

Work Phone: _____

Insurance Information

Primary

Insurance Company Name:* _____

Insurance Phone Number: _____

Policy Holder Name:* _____

Policy Holder Date of Birth:* _____

Policy Holder SSN: _____

Member ID/Policy #:* _____

Group #: _____

Group Name: _____

Secondary

Insurance Company Name: _____

Insurance Phone Number: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy Holder SSN: _____

Member ID/Policy #: _____

Group #: _____

Group Name: _____

Tertiary

Insurance Company Name: _____

Insurance Phone Number: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy Holder SSN: _____

Member 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.

If Liberty Speech Associates LLC is submitting insurance claims on my behalf, 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.

Name of Client:* _____

Today's Date:* _____

Name of Parent/Legal Guardian:* _____

Signature of Parent/Legal Guardian:* _____

Relationship to Client:* _____

Good Faith Estimate & Fee Schedule

A Good Faith Estimate (GFE) outlines the potential out-of-pocket costs associated with your child's evaluation and/or treatment in our office.

CPT® CODES FOR COMMON SERVICES:

Not all codes will apply to your child nor will all codes be charged at every visit.

CPT Code	Description	Rate
92521	Fluency evaluation	$300.00
92522	Speech evaluation	$300.00
92523	Speech & language evaluation	$500.00
92524	Voice & resonance evaluation	$300.00
92507	Speech & language therapy	$130.00
96105	Aphasia evaluation (per hour)	$200.00

1x/week Sessions:

Based on a plan of care that consists of weekly speech and language therapy sessions and 2 evaluations, the estimated total out-of-pocket cost for a calendar year is $7,760. If you are using insurance and have in-network or out-of-network coverage for speech therapy services, your annual costs will likely be considerably lower than the aforementioned estimate dependent upon your applicable copay(s), coinsurance(s) and/or deductible(s). Information provided in this estimate, and any subsequent estimate, is only an estimate and actual items, services, and charges may be different. At any point during treatment, you have the right to engage in dispute resolution if the actual costs of services significantly exceed those listed in the above estimate.

2x/week Sessions:

Based on a plan of care that consists of twice weekly speech and language therapy sessions and 2 evaluations, the estimated total out-of-pocket cost for a calendar year is $14,520.00. If you are using insurance and have in-network or out-of-network coverage for speech therapy services, your annual costs will likely be considerably lower than the aforementioned estimate dependent upon your applicable copay(s), coinsurance(s) and/or deductible(s). Information provided in this estimate, and any subsequent estimate, is only an estimate and actual items, services, and charges

may be different. At any point during treatment, you have the right to engage in dispute resolution if the actual costs of services significantly exceed those listed in the above estimate.

Note: The aforementioned estimates do not account for potential consultative fees (billed at $100/hour) or no show/cancellation fees (billed at $130/appointment) that may be incurred during a calendar year.

This GFE does not obligate you to continue treatment or obtain any of the listed services from Liberty Speech Associates LLC. This GFE lists services that will be furnished at Liberty Speech Associates LLC, 256 Route 31, Washington, NJ 07882 (Tax ID #: 46-3659558) and applies to all providers in this practice, including the initiating provider: Courtney Caruso, M.S., CCC-SLP (NPI # 1639481120).

By signing this document, you acknowledge that you have received and understand your financial responsibilities to this practice if you choose to receive services.

Name of Client:* _____

Today's Date:* _____

Name of Parent/Legal Guardian:* _____

Signature of Parent/Legal Guardian:* _____

Relationship to Client:* _____

Authorization for Student Participation

Liberty Speech Associates LLC participates in clinical education programs with colleges and universities so that speech-language pathology and audiology students can gain experience in clinical practice. As such, your speech-language pathologist may have students observe and/or participate in client care activities, including, where appropriate, providing assessment and treatment to your child under the speech-language pathologist's direct supervision. Your speech-language pathologist will notify you before any student attends or participates in your child's session.

Please indicate your preference below.*

- ☐ I consent to allow students to observe and/or participate in my child's care.
- ☐ I DO NOT consent to allow students to observe and/or participate in my child's care.

Name of Client:* _____

Today's Date:* _____

Name of Parent/Legal Guardian:* _____

Signature of Parent/Legal Guardian:* _____

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.

By signing below:

- 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.

Name of Client:* _____

Today's Date:* _____

Name of Parent/Legal Guardian:* _____

Signature of Parent/Legal Guardian:* _____

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: We may use your protected health information to provide, coordinate, or manage health care and related services, by one or more health care providers. An example of this would include sending a copy of your therapy notes or evaluation to your physician.

Payment: We may use your protected health information for 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: We may use your protected health information for 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 relatives, 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, 2022 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 policies 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