New Client Enrollment Form

(Please Print)

Today's date:				Social Security # (required):		-	-
Client INFORMATION							
Last name:	First:	Middle:	Sex: ( ) M ( ) F		Birth date: / /	Age:	
Mother's Name:	Father's Name:	Guardian's Name:	Mother's Number: ( )				
Street address:	P.O. box/ Home/ Apt #:	Father's Number: ( )					
City:	State:	ZIP Code:	Cell Phone Carrier: _____ Email: _____				
Other family members seen at Speech Tactics:	Additional Number: ( )						
Insurance: ☐ Medicaid	☐ BCBS	☐ Aetna	☐ United Health	☐ TriCare	☐ Cigna	☐ RPN	
☐ MCO	(Please give your insurance card to the receptionist.)						

Daycare/school information			
Daycare/School Name:	Grade Level:		
Teacher's Name:			
Daycare/School Number:			
Does the child have an IEP? ☐ YES ☐ NO	May we request a copy of the client's IEP from the school?	☐ YES	☐ NO

Additional Information	
Primary Pediatrician's Name:	Practice Name:
NPI:	Phone:

IN CASE OF EMERGENCY	
Name of local friend or relative (not living at same address):	Relationship to patient:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*

“NO-SHOW”/CANCELLATION/TARDINESS POLICY

Thank you for choosing **Speech Tactics** for your child’s care. The policies written below are designed to improve our ability to see all of our clients and to provide complete, consistent treatment for your child. We hope these policies will improve our overall service to our families. Since continuity of care is important to maximize the outcomes of your child’s therapy, we use the following guidelines for your appointments:

1. Therapists often are not able to wait more than 15 minutes for a late appointment. **Please notify your therapist as soon as you know you are going to be late.** Because of scheduling constraints, late arrivals may not be able to be seen, and if seen, the session will end at the regularly scheduled time. If you are late **without notification** and your therapist needs to see your child for a shorter amount of time, you will be charged for the entire scheduled session.

2. **24-hour, or more, advance notice for all canceled appointments is mandatory**. If you need to cancel your child’s appointment, our Clinic requires that you cancel 24 hours in advance of the scheduled appointment time. You will be charged $25.00 except in an emergency situation for the scheduled therapy appointment which was missed.

3. Cancellations within the 24 hour window will be recorded as a NO-CALL/NO-SHOW.

4. If you have **2 or more** cancellations within a **1-month period** or you miss more than ½ of your scheduled appointments within the quarter, you may lose your standing appointment time slot. Additionally, your child may be placed on hold for therapy. You will be notified by phone or letter should this occur. If removal from the schedule should occur, in order to be put back on the schedule, a mandatory meeting, or telephone conference, between the family and Clinic Director will be required.

5. **“NO-SHOWS” Cancellations:.** If you do not attend your scheduled appointment and you have not called to give prior notification of the cancellation within 24 hours, you will be considered to be a “No Show” for that appointment. Additionally, a **25.00 penalty fee** will be assessed. If you have two “No Shows” for scheduled appointments, your child’s therapy will be put on hold and you will be notified. Please note that a telephone call after the appointment does not constitute notification and will be considered a “no-show”.

Please sign below. By signing you indicate that you understand the terms outlined above. Thank you for your commitment to your child’s therapy.

Patient’s Name _____ **Parent/Guardian Signature** _____

Therapist Signature _____ **Date** _____

To cancel an appointment, call our office at **980-422-5887** OR email at **info@myspeechtactics.com**

Consent for Release and Retrieval of Protected Health Information

By signing below, I am indicating that I give consent for Speech Tactics to share information checked below with the entities listed. that will be used or shared includes (check all that apply):

☐ My medical records from my PCP/MD.

☐ My treatment records (progress notes, daily records)

☐ My speech and/or occupational evaluation results

☐ Other:

This information can be shared with: _____

I give consent for Speech Tactics to retrieve the following protected health information from the entities stated below: (check all that apply)

☐ My medical records from my PCP/MD.
☐ IEP from my child's school: _____
☐ My speech and/or occupational evaluation results from: _____
☐ Other: _____
_

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time in the form of a written request.
- Any information that was used or shared before I took back the authorization cannot be returned.
- The person or organization that gets my health information because of this authorization may have the right to share it with others without my permission.

Print: _____

Signature: _____ Date: _____

Documentation:
Therapy visits will be conducted at the location agreed upon by the clinician, family, and/or stated on the IFSP. Our therapy sessions are primarily conducted at our clinics. Our documentation policy states that a clinician may reserve the last **3-*5 minutes*** of each visit for documenting notes or for parent education. Parents/ caregivers are expected to be in the lobby to receive clients at least 5 minutes before the end of the sessions.
Initials: _____

Acknowledgment That You Have Received Our HIPAA Privacy Notice

Speech Tactics 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, evaluation reports, therapy notes, assessment results, progress notes, communication notes, and 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. It also tells you how you can look at and comment on your information. This can be provided to you via email as well, if you choose. All clients have direct access to the HIPAA Privacy Notice on our Website. Please initial to indicate that you received and/or know where to find the HIPAA notice:
Initials: _____

CLIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Speech Tactics for your pediatric and adult communication needs. We are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our client financial responsibility policies.

Client Financial Responsibilities

- The Client (or Client's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the client is required to provide the most correct and updated information regarding insurance.
- Clients are responsible for payment of copays, coinsurance, deductibles and all other Procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Clients may incur, and are responsible for payment of additional charges, if applicable

By my signature below, I hereby authorize assignment of financial benefits directly to Speech Tactics and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Your signature below verifies that you understand the information given above

Print Patient's Name	Date
Patient or Parent/Guardian **Print Name** and **Signature**	Relationship to Patient