PediaSpeech Services, Inc.

4028 Holcomb Bridge Rd., Suite 202 • Norcross, GA 30092 • Phone: (770) 209-9826 • Fax: (770) 209-9876

Dear Parent(s):

Welcome to PediaSpeech Services, Inc. We are so pleased that you have chosen us for your child's speech and/or occupational therapy needs. Be assured that every effort will be made to insure that their experience is both a productive and a pleasant one. Our goal is to help your child achieve his/her fullest potential, while at the same time having fun.

There are a few things that we will need to obtain from you before we actually begin therapy. Enclosed you will find a "Patient Information Packet". Each sheet is very important, and therefore we ask that you read them carefully and complete them as accurately as possible. If there is a portion that does not apply, simply enter "NA". Please review the items listed below, and be sure that we have the items that apply in our office by your initial visit.

Therapy cannot begin unless we have all of the following on file:

- Patient Information sheet
- Medical Case History sheet
- **ORIGINAL RX** (required from physician if filing with Insurance or Medicaid). This is required to document medical necessity. It is independent of any additional requirements for a referral or authorization that your insurance might require.
- Copy of insurance card (front and back) (if applicable)
- Copy of Medicaid card (if applicable)
- *Signed* Consent to treat form (attached)
- *Signed* Cancellation Policy (attached)
- IEP (school) or IFSP (Babies Can't Wait) if applicable

We will be happy to bill your insurance company for you; however, **you are responsible for contacting your insurance company prior to your first visit in order to determine your benefits for speech therapy**. Any unpaid balances become your responsibility.

The attached *Insurance Billing Information*, *Privacy Policy* statement, as well as our *Driving Instructions* are included for your information only and DO NOT need to be returned to us.

Please contact us at (770) 209-9826 if you have any questions.

Sincerely,

The Staff at Pediaspeech

Patient Information

Name: ____

Male ______ **Female** ______ **Date of Birth:** ______________________________

Street Address ____

City ________________________________ **Zip** ______________ **Home phone** ______________

Parent/Guardian Name ____________________ ____________________ **Cell Ph.** __________________

Email ____ **Work Ph.** __________________

Referring Physician: ____

Clinic Name: ____ **Phone:** __________________

Clinic Address: ____

Reason for Referral: ____

Diagnostic code (if known) ____

Funding Information: Check those that apply and provide copy of insurance card.

___ **Private Pay**

___ **Medicaid ID:** ____

___ **Insurance Company Name:** ____________________________________

____ **HMO** ____ **POS** ____ **PPO** _____ **Other (specify)** ______________________

Insured's Name: ____

Insured's SSN and DOB: ____

Member ID#: ____________________________ **Group#:** ____________________________

Pre Certification Required? Yes/ No (circle one)

Patient Medical Information

Today's Date: ______________________

Patient Name: ____Date of Birth _____________

Parent/Guardian's Name(s): ____

Siblings Names and Ages: ____

____

Reasons for Referral: ____

Medical History

Please circle appropriate and complete all questions

Prenatal/Neonatal History:

With this pregnancy were there any complications? **Yes/No**

If Yes, please explain: ____

Was this pregnancy full-term? **Yes/No**

If no, gestational age: ____

Was labor induced? **Yes/No**

Was Baby delivered vaginally? **Yes/No**

Was baby in NICU? **Yes/No**

If Yes, please explain: ____

Did baby require NG tube, OG tube or G-tube? **Yes/No**

If Yes, please explain: ____

Feeding History:

Is there a history of problems with sucking, swallowing or feeding? **Yes/No**

If Yes, please explain: ____

Is there a history of reflux? **Yes/No**

Does your child drink from an open cup? **Yes/No**

Does your child drink from a covered cup? **Yes/No**

History of Illnesses:

History of ear infections? **Yes/No**

If Yes, is there a diagnosis of chronic Otitis Media (OM)? **Yes/No**

History of Seizures? **Yes/No**

Has your child had any special tests done (i.e. MRI scan)? **Yes/No**

If Yes, please explain: ____

Has your child had a recent Hearing Test? **Yes/No**

If Yes, what was the date and result: ____

Other relevant illnesses and dates:

____

____

Hospitalizations:

Hospital: Date: Reason:

____

____

____

____

Current Medications:

Name of Medication: Prescribing Reason:

____

____

____

____

Speech-Language Development:

Do you have concerns about speech/language development? **Yes/No**

If Yes, please explain: ____

____

____

____

____

____

Does your child:

	YES	NO	What Age?
Babble/Coo			
Imitate Words			
Produce Words			
Produce Sentences			
Look in the Direction of Sounds			
Follow Simple Commands			

(Completed if child is receiving occupational therapy):

PLEASE CHECK ANY THAT APPLY TO YOUR CHILD :

GROSS MOTOR MILESTONE

PLEASE INDICATE THE AGES AT WHICH THESE MILESTONES OCCURRED:

ROLLING____________ SITTING______________ CRAWLING______________WALKING_______________

DESCRIBE ANY AWKWARDNESS OR CLUMSINESS:

____

ORAL MOTOR MILESTONE

PLEASE INDICATE IF YOU CHILD HAS OR HAD PROBLEMS IN ANY OF THE FOLLOWING AREAS:

SUCKING_______ CHEWING__________ SWALLOWING___________BREATHING________

DOES YOUR CHILD CONTINUE TO HAVE PROBLEMS IN ANY OF THESE AREAS? IF SO PLEASE INDICATE:

____

____

____

SENSORY

DOES YOUR CHILD DISLIKE OR IS OVERLY SENSITIVE TO ANY OF THE FOLLOWING:

______GLUE ______SAND _____ NAILS TRIMMING _____WATER _____GRASS

______MEAT ______SPINNING _____ TOOTH BRUSHING _____HAIR CUT _____CLIMBING

______SWINGING _______LOUD NOISES_______CLOTHING TAGS

DOES YOUR CHILD SEEK OUT:

______ ROCKING ______ TWIRLING _____ SPINNING _______ROUGH HOUSE

______ JUMPING ______ TEXTURES _____ MOUTHING TOYS

DOES YOU CHILD APPEAR:

______INSENSITIVE TO PAIN ______DISTRACTED BY SOUND ______AGGRESSIVE

______CLUMSY ______EASILY FUSTRATED

______ TO HAVE DIFFICULTY WITH PUZZLES / MANIPULATIVES

PLEASE ADD ANY ADDITIONAL COMMENTS REGARDING THE ABOVE SENSORY ITEMS THAT WERE CHECKED, IF NEEDED: ____

____

SELF HELP: PLEASE CHECK ANY THAT YOUR CHILD HAS DIFFICULTY DOING.

____ USING UTENSILS (SPOON, KNIFE, FORK) (Circle what applies)

____ BRUSHING TEETH

____ DRINKING FROM A CUP

____ POURING INTO A CONTAINER

____ BATHING

____ TOILETING

DRESSING:

PUTTING ON:

____ SHIRT/ PANTS (Circle what applies)

____ UNDER CLOTHES

____ SHOES

____ TYING SHOES (IF OVER THE AGE OF 5 YEARS)

REMOVING:

____SHIRT/PANTS (Circle what applies)

____ UNDER CLOTHES

____ SHOES

ZIPPING:

____ JACKET / COAT / PANTS (Circle what applies)

____ STARTING THE ZIPPER ON THE JACKET/ COAT

BUTTONING:

____ JACKET / COAT / PANTS (Circle what applies)

____ SMALL BUTTONS

____ LARGE BUTTONS

____ SNAPS

School Therapy History:

Does your child attend school? **Yes/No**

If Yes, what school? ______________ ____

What kind of classroom? ____

Has /does your child receive other therapies? **Yes/No**

If Yes, please explain ____

Are there other concerns you have? **Yes/ No**

If Yes, please explain ____

____

____

____

CONSENT FOR USE AND DISCLOSURE for PAYMENT & HEALTHCARE OPERATION RIGHT TO RESTICT AND/OR REVOKE AUTHORIZATION

Patient Name: ____

Section A: Consent for Treatment, Payment and health Care Operations

I hereby consent for the use or disclosure of my individually identifiable health information to carry out treatment, payment or health care operations. This includes assignment of benefits.

In other words, please list the healthcare professionals (i.e. pediatricians, schools etc.) that you give our office authorization to send a copy of the paperwork to and/or discuss results of the evaluation on-going progress etc.

This consent is authorized for the following health care provider(s):

Name:_____________________________________Address:____

Name:_____________________________________Address:____

Name:_____________________________________Address:____

I understand that I have the right to review this office's Notice of Information Practices as displayed in the waiting room.
I have received a copy, and read the Notice of Information Practices posted in this office and understand its meaning.
I understand that I have the right to request that this provider restrict how protected health information is used or disclosed to carry out treatment, payment or healthcare operations. And that the provider is not required to requested restrictions.
I have the right to revoke the consent in writing except to the extent that the provider has taken action prior to the revocation. I understand that this authorization is voluntary.

____

Signature of patient or patient's representative Date

Printed name of patient's representative: ___________________Relationship to Patient: __________________________

PAYMENT FOR SERVICES AND CANCELLATION POLICY

Payment for Services Rendered:

Our current prices are as follows:

PROCEDURE	PRICE
Evaluation	$ 200.00
Extended Evaluation	$ 240.00
Speech/Language Therapy	$62.50/30 minutes or 125.00/hr
Feeding/Oral Motor Therapy	$62.50/30 minutes or 125.00/hr
Occupational Therapy	$135.00/hour
IEP Family Conference	$ 125.00/hour

We bill your insurance our current fees and accept their allowable amounts as payment only if we are their in-network provider. We do require payment for services rendered at the time of service. This means that any copays or co-insurance that you are responsible for will be collected at the time of your visit. If you have an annual deductible that has not been met yet, this too will be collected at the time of service.

Our office will work with you and your family in every way possible to locate funding sources for therapy. We will help you determine if your particular plan includes speech benefits for your child. However, you need to be aware that we CANNOT TAKE ANY RESPONSIBILITY for the DECISIONS made by YOUR INSURANCE COMPANY.

You are ultimately responsible for payment of therapy services rendered should all other sources default.

Cancellations and No-shows:

Your child's therapist will set up a standing appointment time. This time is set aside for ***your*** child. We understand that situations arise that will prevent you from keeping your child's appointment. In this case we ask that you notify your therapist at least four (4) hours prior to your appointment time.

There will be a charge of $62.50 for any missed appointment **without prior notification.** You also risk losing your time slot and your therapist may consider giving your time to another child.

I have read and understand the above Payment for Services and Cancellation Policies:

____

Child's Name

____

Parent's Signature Date

INSURANCE BILLING INFORMATION

Dear Parent(s):

We are honored that you have chosen our practice to help your child with their communication needs. In order for us to continue treating your child without stoppage in therapy and to encourage efficient billing and payment processes we request your assistance.

CONTACT YOUR INSURANCE

Prior to your first appointment it is **imperative** that you contact your insurance company to determine your child' speech benefits. *Insurance coverage **DOES NOT** guarantee speech therapy benefits. Those benefits are plan-specific.*

A few tips to help you complete this process (always write down the name of your insurance rep.):

DIAGNOSIS

Your insurance company will request from you the "diagnosis" for your child. Your pediatrician should be the provider who supplies you with the diagnosis. Many ***insurance companies will not reimburse "developmental" diagnoses such as "speech delay"***. Diagnoses that are "disorders" or "disturbances" tend to be covered more often. Speak with your pediatrician to determine the most appropriate diagnosis for your child's difficulties.

TREATMENT CODES

Your insurance company may ask you what treatment/procedure codes will be billed by our therapists. The most common procedural codes that our therapists will use to bill are: 92506 = Speech Evaluation and 92507 = Speech Therapy; Occupational Therapy Evaluation = 97003 and Therapeutic Activity = 97530.

PEDIASPEECH BILLING

Finally, once you have determined what your child's insurance benefits for their speech therapy or occupational therapy needs are, please contact our billing manager, **Renata Kulpa** with the details. She will be the one who directly bills your insurance company. Renata can be reached most easily through her email but feel free to leave her a voicemail and she will return your call as soon as possible.

Renata Kulpa

Email: **rkulpa@pediaspeech.com**

Phone: 770-209-9826, ext. 102

We appreciate your assistance with these billing matters so that our office can make this process as efficient for you as possible.

Sincerely,

PediaSpeech Staff

OUR MEMBER CONFIDENTIALITY STATEMENT

We protect the confidentiality of our members' personal financial and health information as requested by law and accreditation standards and our internal procedures. This Member Confidentiality Statement explains your rights, our legal duties and our privacy practices.

Your Financial Information

In order to conduct health care activities, we collect and use several different types of financial information. This includes information that you provide directly to us on applications or other forms, such as your name, address, age and information about dependents. We accumulate information about your transactions with insurances companies such as eligibility, coverage and deductibles.

We use physical, electronic and procedural safeguards to protect your confidential information. We make it available only to our employees, affiliates or others who need it to service or maintain your account, to conduct insurance transactions and functions, or for other legally permitted or required purposes.

Your Health Information

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.

We collect, use and disclose information provided by and about you for health care operations or when we are otherwise permitted or required by law to do so.

For Payment: We may use and disclose information about you in managing your account and collecting payment for claims for medical care you receive through your plan. For example, we maintain information about your deductible payments and co-pays.

For Health Care Operations: We may use or disclose medical information about you for our operations. For example, we may use information about you to review the quality of care and services you receive.

We may, in the case of some health plans, share limited health information when required by your health insurance company to determine if treatment is medically necessary. Insurance companies that receive this information are required by law to have safeguards in place to protect it from inappropriate uses.

As Permitted or Required by Law: Information about you may be used or disclosed to regulatory agencies, such as during audits, licensure or other proceedings; for administrative or judicial proceedings ; to public health authorities; or to law enforcement officials, such as to comply with a court order or subpoena

Authorization: Other uses and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at any time in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Under regulations that will be in effect in April 2003, you will have additional rights over your health information. Under the new rules, you will have the right to:

- Send us written request to see or get a copy of information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your physician.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address, if communications to your home address could endanger you.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14, 2003.

Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government.

Copies and Changes

You have the right to receive and additional copy of this notice at any time.

We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through direct mail and/or our website.

Contact Information

If you want to exercise your rights under this notice or if you wish to communicate with us about privacy issues or to file a complaint with us, please contact Information and Privacy Security Officer at 770-209-9826.

Directions to PediaSpeech Services Offices:

Norcross: 4028 Holcomb Bridge Rd, Suite 202, Norcross, GA 30092

From I-85: Take Jimmy Carter exit NW. Go approximately 1.5 miles (Jimmy Carter becomes Holcomb Bridge after approx. ½ mile) and turn right into to our office park. Suite 202 is around the back of the first building. Follow the signs.

From I-285: Take 141 North to Jimmy Carter exit and follow directions above.

From 400: Take Holcomb Bridge Rd. Travel East on Holcomb Bridge Rd. approximately 5.5 miles. Cross over Spalding Drive and our office complex is on the left. Suite 202 is around the back of the first building. Follow signs.

Decatur Office/Dekalb Pediatrics*: 350 Winn Way Decatur, GA 30030

From Atlanta and I-75/I-85: Take Freedom Parkway exit to Ponce De Leon. Take Ponce De Leon South/East into Downtown Decatur. Make Left at Commerce Dr. (CVS on the corner). Make another Left at Church St. (McDonalds on corner); Make a Right on North Decatur Rd, and then Right onto Winn Way (Dekalb Medical on Corner). Office is about ½ mile on right. Sign for Dekalb Pediatrics.

From I -285: Take exit 39A Stone Mountain PKWY/US-78. Continue on Lawrenceville HWY for approx. 1 1/2 miles. Veer left onto Church Rd. Go approx. 1 mile. Left on North Decatur Rd. At first light turn right on Winn Way. Office is ½ mile on right. Sign for Dekalb Pediatrics.

***NOTE: We are located in Dekalb Pediatrics offices. Our office is around the back left of the building. Follow the signs to the correct door. Walk in and sit in the waiting room where your treating therapist will come and get you at your designated time.**

Lawrenceville/Therapy Works: 1509 Atkinson Rd., Suite 1100 Lawrenceville, GA 30043

From 85 Northbound: Take 316 East heading towards Athens. Take the Sugarloaf Pkwy exit. Turn left onto Sugarloaf Pkwy. Go approx. One mile and turn left onto Atkinson Rd. Take the first entrance into the office complex immediately on your right. Therapy Works is the one story office building to the left. Suite 1100.

From 85 Southbound: **T**ake the Sugarloaf Pkwy Exit (108). Turn left onto Sugarloaf Pkwy. Go approximately five (5) miles (you will pass Discovery Mills). Turn right onto Atkinson Rd. Take the first entrance into the office. Therapy Works is the one story office building to the left. Suite 1100

NOTE: We are located in Therapy Works, PC offices, a physical and occupational therapy company. Please come in and wait in waiting room. Your therapist will come to get you in the waiting room.