

# PediaSpeech Services, Inc.

6075 Atlantic Blvd. Suite G-1 • Norcross, GA 30071 • 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 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. Please be sure to bring these items with you on your first visit. Following, 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 "N/A" or "Not Applicable". Please review the items listed below, and be sure that we have the items that apply in our office by your initial visit.

**Therapy can not begin unless we have all of the following on file.**

- Patient Information Sheet
- Case History Sheet
- **ORIGINAL RX** (required from physician if filing w/ Insurance or Medicaid)
- Copy of front and back of Insurance Card (if applicable)
- Copy of Medicaid Card (if applicable)
- *Signed* Consent to Treat Form
- *Signed* Cancellation Policy

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.

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

\_\_\_ Insurance - Company Name: \_\_\_\_\_

\_\_\_ HMO \_\_\_ POS \_\_\_ PPO \_\_\_ Other (specify) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Billing Phone: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's SSN: \_\_\_\_\_

Member ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Pre Cert Req'd? Yes/ No (circle one)

\_\_\_ Babies Can't Wait (BCW)

Cost Participation: \_\_\_\_\_%

Service Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_ Medicaid: \_\_\_\_\_

## 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, please explain: \_\_\_\_\_

Other relevant illnesses and dates:

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**Hospitalizations:**

Hospital:

Date:

Reason:

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**Current Medications:**

Name of Medication:

Prescribing Reason:

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**Speech-Language Development:**

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

If Yes, please explain: \_\_\_\_\_

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**Does your child:**

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

**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 \_\_\_\_\_

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# PediaSpeech Services, Inc

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

Patient Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

### 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.

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

(You may need to include more than one if you see multiple doctors, nurse practitioners, physician assistants, within the same office)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

List Requested Restrictions

Approved/Denied by Provider

\_\_\_\_\_  
\_\_\_\_\_

Specific description of information (including date(s)):

\_\_\_\_\_  
\_\_\_\_\_

Signature of patient or patient's representative

Date

Printed name of patient's representative: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I want to revoke my authorization for treatment, payment and health care operations beginning on date) \_\_\_\_\_

Signature of patient or patient's representative

Date

## 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 insurance 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 an 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.

## PediaSpeech Services, Inc

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### 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's speech benefits. *Insurance coverage DOES NOT guarantee speech therapy benefits. Those benefits are plan specific.*

Our office **WILL NOT** do pre-certification or contact your insurance company before your first visit, this is your responsibility.

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.

#### **PEDIASPEECH BILLING**

Finally, once you have determined what your child's insurance benefits for their speech therapy needs are, please contact our billing manager, Michelle Murphy with the details. She will be the one who directly bills your insurance company. Michelle 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**

#### Contact Information

Email: [rkulpa@pediaspeech.com](mailto:rkulpa@pediaspeech.com)

Phone: 770-209-9826 ext 104

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

Sincerely,

The PediaSpeech Staff

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**Payment for Services and Cancellation Policy**

Thank you for choosing PediaSpeech Services, Inc. and allowing us the opportunity to teach your child to communicate!

**Payment for Services Rendered:**

Although we wish we could provide our services free of charge, we unfortunately do require payment for services rendered. Our current prices are as follows:

PROCEDURE	PRICE
Evaluation	\$ 200.00
Extended Evaluation	\$ 240.00
Speech/Lang Therapy	\$ 125/hr
Feeding/Oral Motor	\$ 125/hr
Cognitive/Linguistic	\$ 31.25/unit
Sensory Integration	\$ 31.25/unit
Augmentative	\$ 54.75/unit
IEP Family Conference	\$ 125/hour

Our office will work with you and your family in every way possible to locate funding sources for therapy. However, you need to be aware that you are ultimately responsible for payment of therapy services rendered should all other sources default.

**Cancellations:**

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. However, if you are unable to keep your appointment time **without** notification on any two (2) occasions, you 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:

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 Child's Name

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 Parent's Signature

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 Date

## Directions To PediaSpeech Services Offices

### **Peachtree Corners/Norcross (Until 9/11/2009):**

**6075 Atlantic Blvd. Suite G-1  
Norcross, GA 30071**

#### **From I-85**

Take Jimmy Carter Blvd NW (towards Norcross). **Right** on Atlantic Blvd. At 1<sup>st</sup> traffic light (Holcomb Bridge), make a **left**. Then 1<sup>st</sup> **left** into Crossing Center VI. Cross wooden bridge, keep right to Bldg 6075, Suite G-1

#### **From I-285**

Take 141 N, **merge** onto Peachtree Ind. Blvd. **Right** onto Holcomb Bridge Rd. Turn **right** at 3<sup>rd</sup> driveway into Crossing Center VI. Cross wooden bridge, **keep right** to Bldg. 6075, Suite G-1

#### **From Hwy 400**

Take Holcomb Bridge Rd. exit towards Norcross (travel approx. 4 miles). Pass Pikes Nursery, then Burger King on the right. Approx. ¼ mile past Burger King, Holcomb Bridge **bears left**. Continue on Holcomb Bridge. Go through 2<sup>nd</sup> light (Peachtree Ind. Blvd/Hwy 141). Turn **right** at 3<sup>rd</sup> driveway into Crossing Center VI. Cross wooden bridge, keep **right** to Bldg. 6075, Suite G-1

#### **From I-75**

Take 285 East. Take 141 N, **merge** onto Peachtree Ind. Blvd. **Right** onto Holcomb Bridge Rd. Turn **right** at 3<sup>rd</sup> driveway into Crossing Center VI. Cross wooden bridge, **keep right** to Bldg. 6075, Suite G-1

### **\*New Peachtree Corners/Norcross Office (After 9/11/2009):**

**4028 Holcomb Bridge Rd. Suite 202  
Norcross, GA 30092**

#### **From I-285**

Take 141 N (Peachtree Industrial Exit), **merge** onto Peachtree Ind. Blvd. **Left** onto Holcomb Bridge Rd. Turn **right** at light and continue on Holcomb Bridge. Office Complex is 1.4 miles on right. Suite is around to right in the back of the first building.

#### **From I-85**

Take Jimmy Carter Blvd NW (towards Norcross). After you go under Peachtree Industrial Rd. office complex is approx. 2 miles on right before Spalding Dr. Suite is around to right in the back of the first building.

#### **From Hwy 400**

Take Holcomb Bridge Rd. exit towards Norcross (travel approx. 4 miles). Pass Spalding Rd. office complex is on the left. Suite is around to right in the back of the first building.

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### **Decatur Office/Dekalb Pediatrics\***

**350 Winn Way  
Decatur, GA 30030**

Continued on next page – Lawrenceville and Suwanee Clinic Directions

**Directions Continued**

**From Atlanta and I-75 / I-85**

Take Freedom Parkway exit to Ponce De Leon Ave. 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. See 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. Turn **left** on North Decatur Rd. At first light turn **right** on Winn Way. Office is ½ mile on right. See sign for Dekalb Pediatrics.

**\*NOTE: We are located in Dekalb Pediatrics offices. Our offices are to the left around the back of the building. Follow signs to the correct door and waiting room. Your therapist will come to get you in the waiting room.\***

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**Lawrenceville/Therapy Works\***

**1509 Atkinson Rd., Suite 1100  
Lawrenceville, GA 30043**

**From I-85 Northbound**

Take Hwy 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 I-85 Southbound**

Take the Sugarloaf Pkwy Exit (108). Turn **left** onto Sugarloaf Pkwy. Go approximately five miles (you will pass Discovery Mills Shopping Center). 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 into the waiting room. Your therapist will come to get you in the waiting room.\***

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**Suwanee/Pediatric Therapy Services\***

**4411 Suwanee Dam Rd., Suite 455  
Suwanee, GA 30024**

**From I-85 (both North and South)**

Take exit 111 for GA-317 North towards Suwanee. Turn **left** onto Suwanee Rd. NW. Suwanee Rd. turns into Suwanee Dam Rd. Go approx. 2.5 miles. Office 1<sup>st</sup> right past Peachtree Industrial Rd. Turn into Crossing office complex, make an immediate right and continue around. Our office is on the left (sign says Pediatric Therapy Services).

**Continued on next page**

**Directions Continued**

**From North on Peachtree Industrial Blvd.**

Suwanee Dam Rd. is approx three miles south of Cumming Hwy/GA 20. Make a ***right*** onto Suwanee Dam Rd. (BP Station and CVS Pharmacy at intersection) then 1<sup>st</sup> ***right*** into the Crossing office complex. Make an immediate right and continue around. Our office is on the left (sign says Pediatric Therapy Services).

**From South on Peachtree Ind. Blvd.**

Suwanee Dam Rd. is approx four miles north of Sugarloaf Pkwy. Make left at Suwanee Dam Rd then 1<sup>st</sup> ***right*** into the Crossing office complex. Make an immediate right and continue around. Our office is on the left (sign says Pediatric Therapy Services).

**\*NOTE: We are located in Pediatric Therapy Services office, a physical and occupational therapy company. Please come into the waiting room. Your therapist will come to get you in the waiting room.\***