PediaSpeech Services, Inc.

www.pediaspeech.com • (770) 209-9826 • Fax: (770) 209-9876 • Decatur, Georgia

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 or at the first scheduled visit. Attached 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)/ IFSP (Babies Can't Wait) if applicable (REQUIRED FOR ALL MEDICAID CLIENTS)

We will be happy to bill your insurance company for you; however, 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

PediaSpeech Services, Inc.

Date:_____

Name: _____ DOB: _____ M or F

Address: _____

City: _____ Zip: _____ Primary Parent:_____

Secondary Parent/Guardian:_____

Primary: _____ _____Cell _____Home _____Work

Secondary: _____ _____Cell _____Home _____Work

E-mail: _____

Alternate Caregiver:_____ Grandparent _____ Nanny _____ Friend _____

Referring Physician:_____ Phone :_____

Pediatrician:_____ Phone:_____Fax:_____

Address:_____

Reason for Referral (diagnosis):_____

Outside Evaluation/Therapy Date:_____ Report:_____

FUNDING SOURCE: **We do not accept: <u>Amerigroup</u>, <u>Peach State</u> or <u>WellCare</u> Mediciad**

_____ Private Pay

_____ Insurance: Name of carrier & provider phone #: _____

ID #: _____Group #: _____

Primary Insured:_____ DOB:_____

Secondary Carrier:_____ See Card Details

_____PPO _____ POS _____ HMO _____ OTHER (specify) _____

_____MEDICAID: ID#: _____SSI _____ Waiver_____

PediaSpeech Services, Inc.

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**

Other History:

Has your child been diagnosed with Autism? _____ Any other medical diagnosis?_____

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 only 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 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)

____ LARGE BUTTONS

____ SMALL 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 indicate type of therapy/start date and discharge date?

_____

_____

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

If Yes, please explain _____

_____

_____

AUTHORIZATION FOR CONSENT TO TREATMENT

I, _____, hereby authorize PediaSpeech Services Inc.
(*your name & relationship)*
to consent to obtain the following medical treatment for _____
(name of child)

for all speech and occupational therapy services. This authorization is will be in effect until the end services are terminated. I accept responsibility for all charges related to treatment by reason of this authorization.

Signature_____ Date _____
(Parent or legal guardian)

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

Patient Name: _____

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), care givers or family that you give our office permission to send paperwork and/or discuss results of the evaluation plus on-going progress etc.

This consent is authorized for the following health care provider(s)/pediatrician and caregivers.

Name:_____Address:_____

Name:_____Address:_____

Name:_____Address:_____

I understand that I have the right to review this office's Notice of Information Practices upon request or receive an electronic copy via e-mail. 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. I have the right to revoke this 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's representative Date

Printed name of patient's representative: _____

Relationship to Patient: _____

PediaSpeech Services, Inc

I _____, do hereby give PediaSpeech Services, Inc. their assigns, licenses, and legal representatives the right to use picture, portrait, photograph or image in all forms and media and in all manners, including composite or purpose, and I waive any right to inspect or approve the finished product, including written copy, that may be created in connection therewith. I also agree that this releases PediaSpeech Services, Inc. and any and all of its representatives from any and all monetary obligations or payments to me or any or all of my authorized representatives for use of video, photographs and images. No full names will be used in posting these photos in any online locations. I am of full legal age. I have read this release and am fully familiar with its contents.

Name:	Date:
Signature:	

Consent for Minor

I am the parent or legal guardian of the minor named above and have the legal authority to execute the above release. I approve the foregoing and waive any rights in the premises.

Name	Date:
Signature:	

PAYMENT FOR SERVICES AND CANCELLATION POLICY

Payment for Services Rendered:

Our current prices are as follows:

PROCEDURE	PRICE
Evaluation	Starting at $250.00 (*dependent on procedure performed)
Speech/Language Therapy	$65.00/30 minutes or 130.00/hr
Feeding/Oral Motor Therapy	$65.00/30 minutes or 130.00/hr
Occupational Therapy	$70.00/30 minutes or $140.00/hour
IEP Family Conference	$130.00/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 co-pays 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 therapy 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 ($65 for speech therapy and $70 for occupational therapy) 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

After your child's evaluation you will be given a form with specific CPT and Diagnosis codes and you can check with your insurance to see if covered

*Insurance coverage **DOES NOT** guarantee payment of 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

92523 = Evaluation of Language comprehension and expression
92610 = Swallowing Function Evaluation
97166 = Occupational Therapy Evaluation
92507 = Speech Therapy
92526 = Swallowing Dysfunction Therapy
97530 = Therapeutic Activity

After your child's evaluation you will be given a form with specific CPT and Diagnosis codes and you can check with your insurance to see if covered

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 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 available 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 effective since April 2003, you have additional rights over your health information. Under the new rules, you 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.

Directions to PediaSpeech Services Office:

Decatur Office: Winn Medical Center – 495 Winn Way, Suite 210, 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 a 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 1/3 mile on the left in the Winn Medical Center. We are in the corner suite of building 495 – Suite 210.

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 and take a left on North Decatur Rd. At first light turn right on Winn Way. Office is 1/3 mile on the left in the Winn Medical Center. We are in the corner suite of building 495 – Suite 210.