National Speech/Language Therapy Center

DBA: National Therapy Center, Inc.

SPEECH THERAPY • OCCUPATIONAL THERAPY • ABA THERAPY

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Washington, DC 20003
Phone: 202.470.4185
Fax: 1.833.803.2521

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5606 Shields Dr.
Bethesda, MD 20817
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20400 Observation Dr. Ste. 104
Germantown, MD 20876
Phone: 301.540.0445
Fax: 1.833.803.2521

•

1934 Old Gallows Rd. Ste. 350
Tysons Corner, VA 22182
Phone: 301.493.0023
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1100 N. Glebe Rd. Ste. 1010
Arlington, VA 22201
Phone: 301.493.0023
Fax: 1.833.803.2521

Welcome!

Thank you for choosing National Therapy Center. We realize there are many options from which to choose and we appreciate the opportunity to assist you with this important process.

The staff at National Therapy Center are consummate professionals who are committed to mutually held values of integrity, service, professionalism, and research-based evaluation and treatment. We actively seek to collaborate with families and other professionals to effectively meet each individual's needs by ensuring the use of evidence-based practice and customizing programs for each client.

This packet contains important information about our services, financial obligations, insurance company guidelines and regulations, as well as forms for you to complete. We ask that this be completed prior to evaluation and treatment. Please take time to read all the information carefully and feel free to ask any questions as you go through this process.

Completed forms may be turned in to the front office staff or your providing therapist.

Our services are part of a cooperative effort between our staff and the clients we serve. Together we can make a difference and we look forward to working with you!

Sincerely,

The Staff at National Therapy Center.

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GENERAL GUIDELINES

The following information is a list of general guidelines that will assist in creating a treatment environment that is as efficient and smooth as possible. If you have any questions, please speak with your therapist.

1. Please have your child dressed in clothing that is easy to move in and is OK if it gets dirty.
2. If you want to observe the treatment session, please discuss this with your therapist first. Due to the HIPAA privacy laws, there is a specific procedure that must be followed to ensure the privacy of other clients at the office.
3. Individual treatment sessions range between 25-50 minutes. The last 10 minutes of the treatment session may be used for family education, discussion and documentation. If you feel that you need additional time to discuss issues, please schedule that time with your therapist. This will prevent running into the next appointment. If you leave the clinic during your child's therapy time, please return 10 minutes prior to the end of the session to allow ample time for your therapist to discuss the session and complete documentation.
4. You will be notified as far in advance as possible when your therapist is ill, on vacation or attending a conference. Every effort will be made to reschedule your appointments so that your child will miss as little treatment as possible.
5. A client may be sent home because of a health need if he/she:
    - Appears ill and is unable to participate in therapy.
    - Is suspected of having a contagious disease/condition.
    - Sustains an injury which needs medical attention or close observation.
    - Exhibits vomiting or diarrhea or has yellow or green mucus, indicating infection.
    - Has a fever of 100.4 or greater (a client may not return to National Therapy until they are fever free for 24 hours without fever reducing medication such as Tylenol or Motrin).
7. Please leave information on how to contact you in case of any emergencies. Also, please be prompt in picking up your child before their session is over. We do not have the means for childcare. Failure to return in a timely manner will result in a fee and a requirement that you do not leave the premises during your child's treatment.
8. Cancellation/Missed Appointment Policy: Please provide 24-hours notice to cancel an appointment or if your child is sick when he or she wakes up, call or email first thing on the morning of the missed appointment and leave a voicemail. If you do not call more than an hour before a missed appointment, this is a no-show. ***You will be charged the full session fee if you No Show.*** You may nullify the fee by rescheduling your appointment to take place within five business days of the appointment you cancelled/missed.
9. It is essential, to maximize therapeutic gains of intervention, that you consistently attend your regularly scheduled appointments. Habitual cancellations/ rescheduling or having 3 "no show" cancellations will result in the loss of a reserved time slot and your child will be placed on the waiting list for another time slot. We highly encourage rescheduling appointments when you need to cancel. Thank you for your consideration.

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CLIENT INFORMATION

Date completed:_____

Child's Full Name: _____ **DOB**: _____

Person completing this form:_____ Relationship to child: _____

Gender: _____ Prescription for Services? Yes ☐ No ☐

Referring Physician: _____Physician Phone: _____

*Please note that having a prescription/ referral does not guarantee coverage

Primary Insurance Company: _____

Secondary Insurance Company: _____

Does your child receive: OT _____ PT _____ Other _____

Child lives with: _____

_____

Parent/Caregiver Name: _____

Address: _____

City:_____ State: _____ Zip code: _____

Cell:_____ Work Phone: _____Home: _____

Email Address: _____

Second Parent/Caregiver Name: _____

Address: _____

City:_____ State: _____ Zip code: _____

Cell:_____ Work Phone: _____Home: _____

Email Address: _____

Preferred method of contact: _____

Child's primary language: _____ Secondary Language: _____

Current concerns/reason for referral: _____

_____

_____

When did you first become concerned? _____

_____

_____

MEDICAL INFORMATION

Primary Physician: _____Facility/Practice:_____

_____

Phone: _____

Please list all diagnoses previously given to your child:_____

_____

_____

Please list any medications your child takes and the reason: _____

_____

_____

Please list any other professional Providers (e.g., occupational or physical therapist, speech/language pathologist, counselor, tutor, etc.), including name contact number. If your child is no longer seeing the specialist, please include the approximate dates that service was provided. (*We will not contact any of the following without your written permission).

_____

_____

_____

NOTICE OF PRACTICE POLICIES & FINANCIAL RESPONSIBLITY

- Therapist communication is encouraged and welcome during normal business hours. You may leave a message for your therapist and your call will be returned within 24 hrs.
- All private pay patients are expected to make payment upon arrival for your session. Alternatively, we recommend keeping a credit card on file to be billed all charges.
- For all patients seen out of the office, you MUST keep a credit card on file.
- We accept cash, checks, Visa, MasterCard, and American Express.
- If payment is not made within 30 days, your child's services will be placed on "Hold" until the balance due is paid in full.
- All returned checks will incur a $30 service fee.
- Please inform the office of any cancellations within 24 hours of your appointment time. All Short Notice *(less than 24-hours)* appointment cancellations will be charged at full session fee and **will not be covered by your insurance.**
- Three consecutive "no show" appointments (appointments in which you have not cancelled with 24-hour notice), or habitual cancellations of 3 or more will result in your child's therapy time being rescheduled.
- All parents/caregivers are expected to remain on the premises during a child's session.
- A fee schedule is included in this packet, please be sure to review the list. **By signing this document you agree that you received and reviewed the fee schedule**.
- **Insurance plans vary widely in regard to the benefits they provide, and it is important that you understand your benefits and the limitations. You ARE responsible for paying all copays, deductibles, rejected claims, and balances after insurance payments. Therefore, it is your responsibility to call your insurance company and understand the benefits under the terms of your policy. By signing this document, you agree to financial responsibility of all non-covered fees.**
- Primary insurance **MUST** be given. Failure to do so may result in claim denial making you financially responsible.
- If your status changes with your insurance, **including Medicaid**, you are responsible for informing us. If your child is seen and is no longer eligible for services, you **WILL** be held financially responsible.
- It is your responsibility to notify our administrative team if your child is seen elsewhere for any services. Medicaid law states that we cannot provide the same service on the same day your child receives that service at another location. If this occurs, you **WILL** be held financially responsible.

For families who have both Primary and Secondary Insurance:

You must submit insurance cards for BOTH Primary and Secondary. EOB's MUST be submitted to us EVEN if they are a denial. Without these, we cannot submit to your secondary insurance, and you will be held financially responsible for any services rendered. Please initial here: _____

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred for my child. The undersigned certifies that he/she has been provided the evaluation and treatment costs and is the responsible party and accepts these terms.

_____

Responsible Party Signature Date

PHOTOGRAPH RELEASE FORM

I authorize National Therapy Center to photograph my child for use in the following categories. Parents or other clients may ask the names of the children in the pictures. I authorize that my child's first name may be mentioned when referring to these pictures.

This authorization is valid from the date signed below. I understand that I may revoke this authorization at any time, but will not hold National Speech/ Language Therapy Center Inc. responsible for pictures already taken of my child.

Please check "Yes" or "No" to indicate your preferences.

I Give National Therapy Permission to:	**Yes**	**No**
Take photographs or video for therapeutic purposes	☐	☐
Use photos within the clinic	☐	☐
Use photos on company website	☐	☐
Use photos in flyers, brochures, or publicity ads	☐	☐
Email to parent of videos taken for therapeutic purposes	☐	☐

Name of Child: _____

Caregiver's Name: _____

Caregiver's Signature: _____

Date:_____

CONSENT AND ACKNOWLEDGEMENT

Name of Child: _____

Printed Name of Legal Representative: _____

Consent for Care and Treatment: As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by National Therapy Center staff as is necessary in their judgment. I understand that my child is under the care and supervision of a Speech Language Pathologist, Occupational therapist and/or a Board Certified Behavior Analyst (BCBA). I authorize release of medical information to the National Therapy Center team for continuity of care.

_____ _____

Signature of legal representative of child Date

Acknowledgement of Notice of Privacy Practices: I acknowledge that National Therapy Center Inc. will use and disclose my child's personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. The HIPAA Notice of Privacy Practices provides further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law.

_____ _____

Signature of legal representative of child Date

Consent for Parent Observation: I understand that other parents may see my child in therapy as the parents observe their own child in therapy.

☐ I consent to the presence of other parents in the same treatment area with my child as the observe their child in therapy.

☐ I do not consent to have other parents in the same treatment area as my child.

_____ _____

Signature of legal representative of child Date

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by National Speech/ Language Therapy Center Inc. and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your health care bills, to support the operation of the National Speech/ Language Therapy Center Inc. practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of speech pathology students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is required to obtain medical information according to the privacy rule detailed in HIPPA (The Health Insurance Portability and Accountability Act of 1996).

I _____, parent/guardian of _____

give permission for National Speech/Language Therapy Center to discuss, send and/or receive medical information, including medical records concerning my child.

Child's Name: _____

Child's Date of Birth:_____

Parent/Guardian's Name (Printed): _____

Parent/Guardian's Signature:_____

Date: _____

Please list names and phone numbers of those people with whom we can exchange information. Thank you

NAME PHONE NUMBER

1. _____
2. _____
3. _____
4. _____
5. _____
6._____

PROCEDURE FOR OBSERVING YOUR CHILD

To ensure compliance with HIPAA, parents are only allowed in the treatment area in which their child is working.

To maintain the confidentiality of clients during their therapy session, the following procedures must be observed:

1. Parents choosing to observe must sign this statement of confidentiality.

2. While observing your child's therapy, you may be asked to leave the treatment area or the location of your child's therapy. The location may have to be modified if one of the clients in the treatment area requests that no other parents be in the same area as their child during treatment.

3. Siblings are not allowed in the treatment area unless authorized by the treating therapist for therapeutic reasons.

4. Cell phone use is not allowed in the treatment area.

5. You may stay only in the area in which your child is working.

6. Please respect other client's therapy sessions in the event your presence is distracting. **You may be asked to leave the treatment area if your presence is affecting your child or other client's treatment. In the instance when there is more than one person observing, we may ask that only one person be in the treatment area to protect the quality of treatment.**

Statement of Confidentiality

The undersigned hereby acknowledges his/her responsibility under federal applicable law and the Agreement to keep confidential any information regarding National Speech/ Language Therapy Center Inc.'s patients, as well as all confidential information. The undersigned agrees under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient, and further agrees not to reveal to any third party any confidential information of National Speech, including policies and procedures.

_____

Client's Name DOB

_____

Parent/ Guardian's Signature DATE

CREDIT CARD AUTHORIZATION

National Therapy Center offers the convenience of leaving a credit card on file to handle all applicable fees regarding your therapy.

If you are interested in utilizing your credit card/debit card as a consistent form of payment, please fill out the section below.

I authorize National Speech to keep my signature on file and to charge my account for balance of charges incurred on a monthly basis.

Circle one: Visa ☐ MasterCard ☐ American Express ☐ Discover ☐

☐ All visits this year

☐ All visits from _____ to _____

I understand this form is valid for one year unless I cancel the authorization through written notice or email to National Speech's billing department.

Patient's Name: _____

Card Holders Name: _____

Cardholder's Signature: _____

Account #: _____

Expiration Date: _____ Security Code: _____

Today's Date: _____ ZIP: _____