National Speech / Language Therapy Center, Inc.

5606 Shields Drive • Bethesda, MD 20817 • Tel: 301-493-0023 • Fax: 301-493-8230
19733 Executive Park Circle •Germantown, MD •Phone 301-540-0445•Fax 301-540-0766
412 First Street SE • Rear Building Lower Level • Washington, DC 20003 • Tel: 202-470-4185 • Fax: 202-741-9952
Email: Contact@nationalspeech.com

New Client History

Date completed:

Child's Full Name: _____ DOB: _____

Name of Person completing this form: _____

Relationship to child: _____

Prescription for Services? ☐ Yes or ☐ No

Insurance Provider _____ Secondary insurance_____

Mother/Guardian's Name: _____

Address:_____

Home Phone: _____ Work Phone: _____Cell:_____

Father/Guardian's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell:_____

Child lives with: ☐ mom ☐ dad ☐ both ☐ other_____

Email Address/es:

_____

Preferred method of contact:_____

National Speech / Language Therapy Center, Inc.

5606 Shields Drive • Bethesda, MD 20817 • Tel: 301-493-0023 • Fax: 301-493-8230
19733 Executive Park Circle •Germantown, MD •Phone 301-540-0445•Fax 301-540-0766
412 First Street SE • Rear Building Lower Level • Washington, DC 20003 • Tel: 202-470-4185 • Fax: 202-741-9952
Email: Contact@nationalspeech.com

School/preschool _____

Head Teacher _____

Telephone _____

Pediatrician _____

Address _____

Telephone _____ Fax _____

Who can we thank for referring you:_____

National Speech / Language Therapy Center, Inc.

5606 Shields Drive • Bethesda, MD 20817 • Tel: 301-493-0023 • Fax: 301-493-8230
19733 Executive Park Circle •Germantown, MD •Phone 301-540-0445•Fax 301-540-0766
412 First Street SE • Rear Building Lower Level • Washington, DC 20003 • Tel: 202-470-4185 • Fax: 202-741-9952
Email: Contact@nationalspeech.com

National Speech Fee Schedule

Individual Sessions

• Executive Director (50-minute sessions)	$150.00
• Senior Speech Language Pathologist	$150.00
• Staff Speech Language Pathologist	$135.00
• Speech Language Pathology Assistant	$90.00
• Cognitive Training	$105.00
• Reading Programs	$105.00
• Augmentative Communication (AAC) Services	Special rate, please inquire

Group Sessions

• Group Speech/ Language Therapy	$85.00 per 50-minute session
• Social Skills Group	$85.00 per 50-minute session
• School Break Clinic	Special rate, please inquire
• Co-therapist	$60.00 per therapist per session

Consultations and Evaluations

• Intake (meeting with parents, review of history and reports)	$150.00
• Speech/Language Evaluations*	$350-$900.00
• Reading Evaluations*	$500.00
• Cognitive Skills Evaluation*	$500.00
• Bilingual Speech/Language Evaluation*	$750.00
• Articulation Evaluation*	$200.00
• Child Fluency/Language Evaluation*	$550.00
• Child Fluency Evaluation*	$450.00
• Adult Fluency Consult (with Report)	$200.00 ($350.00)
• Parent Consultation	$75.00
• Consultation with other professionals (phone or in-person)	$75.00 per hour
• Meetings (includes travel to and from office)	$75.00 per hour

**includes written report with recommendations*

Additional Documentation & Fees

• Progress reports (in addition to one per year)**	$75.00
• IEP writing	$75.00
• Treatment plans (in addition to one per year)**	$75.00
• Insurance/billing documentation (one monthly and yearly statement are provider)	$75.00 per hour
• Missed appointments	Full session price
• Late Pick-up	$1.00 per min after 5 min
• Off-site therapy travel	$15.00

ABA Services

- All ABA service fees are determined on a case by case basis.

National Speech / Language Therapy Center, Inc.

5606 Shields Drive • Bethesda, MD 20817 • Tel: 301-493-0023 • Fax: 301-493-8230
19733 Executive Park Circle •Germantown, MD •Phone 301-540-0445•Fax 301-540-0766
412 First Street SE • Rear Building Lower Level • Washington, DC 20003 • Tel: 202-470-4185 • Fax: 202-741-9952
Email: Contact@nationalspeech.com

NOTICE OF PRACTICE POLICIES & FINANCIAL RESPONSIBLITY

- **All private pay patients are requested to make payment upon arrival for your session. We also recommend keeping a credit card on file to be billed every Friday or on a monthly basis for all charges incurred that month.**
- **For all patients seen out of the office, you have the option of paying in advance or keeping a credit card on file.**
- **We accept Cash, Checks, and Credit Cards (Visa, Master)**
- **If payment is not made within 30 days, your child's appointments will be placed on "Hold" until the balance due is paid in full. (See our policy for cancellations/missed appointments)**
- **All Returned Checks will incur a $30 service fee.**
- **Please inform the office of any foreseen cancellations within 24 hours of your appointment time. All *Short Notice (less than 24 hour notice)* appointments cancelations will be charged at full session fee. You may nullify the fee by rescheduling your appointment to take place within five business days of the appointment you cancelled/missed.**
- **Three consecutive "no show" appointments or habitual cancellations will result in the loss of a reserved treatment time slot and/or your child being discharged from therapy.**
- **Children should be promptly picked-up when the therapy session ends (10 minutes prior to the end of your child's session). A fee of $1.00 per minute will be charged if you are more than 5 minutes late**.
- **A fee schedule is included in this packet, please be sure to review the list; by signing this document you are agreeing that you received and reviewed the fee schedule.**
- **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. Please only call your therapist at home or on their cell if you are cancelling an early morning appointment.**

FINANCIAL RESPONSIBILITY

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred by 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

National Speech / Language Therapy Center, Inc.

5606 Shields Drive • Bethesda, MD 20817 • Tel: 301-493-0023 • Fax: 301-493-8230
19733 Executive Park Circle •Germantown, MD •Phone 301-540-0445•Fax 301-540-0766
412 First Street SE • Rear Building Lower Level • Washington, DC 20003 • Tel: 202-470-4185 • Fax: 202-741-9952
Email: Contact@nationalspeech.com

CREDIT CARD AUTHORIZATION

National Speech/ Language Therapy Center, Inc. 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. Thank you.

I authorize National Speech to keep my signature on file and to charge my account for balance of charges incurred on a (weekly) (Bi-weekly) (Monthly) basis.

Circle one: ☐ Visa ☐ MasterCard ☐ American Express

☐ All visits this year

☐ Co-payments

☐ No show or late cancellations charges

☐ All visits from _____ to _____

☐ Recurring charges

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.

Child's Name: _____

Card Holders Name: _____

Cardholder's Signature: _____

Account #: _____

Expiration Date: _____ Security Code: _____

Today's Date: _____ ZIP:_____

National Speech / Language Therapy Center, Inc.

5606 Shields Drive • Bethesda, MD 20817 • Tel: 301-493-0023 • Fax: 301-493-8230
19733 Executive Park Circle •Germantown, MD •Phone 301-540-0445•Fax 301-540-0766
412 First Street SE • Rear Building Lower Level • Washington, DC 20003 • Tel: 202-470-4185 • Fax: 202-741-9952
Email: Contact@nationalspeech.com

PHOTOGRAPH AND VIDEO RELEASE FORM

I authorize National Speech/ Language Therapy Center Inc. 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 Speech Permission to:	**Yes**	**No**
Take photographs or video for therapeutic purposes	☐	☐
Take photographs or video for training 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: _____

Parent's Name: _____

Parent's Signature: _____

Date:_____

National Speech / Language Therapy Center, Inc.

5606 Shields Drive • Bethesda, MD 20817 • Tel: 301-493-0023 • Fax: 301-493-8230
19733 Executive Park Circle •Germantown, MD •Phone 301-540-0445•Fax 301-540-0766
412 First Street SE • Rear Building Lower Level • Washington, DC 20003 • Tel: 202-470-4185 • Fax: 202-741-9952
Email: Contact@nationalspeech.com

CONSENT AND ACKNOWLEDGEMENT

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 my child's speech language pathologist as is necessary in their judgment. I understand that my child is under the care and supervision of a speech language pathologist. I authorize release of medical information to the National Speech team for continuity of care.

_____ _____
Signature of legal representative of child Date

Acknowledgement of Notice of Privacy Practices: I acknowledge that National Speech/ Language 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 observe my child in therapy as the parents observe their child in therapy.

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

National Speech / Language Therapy Center, Inc.

5606 Shields Drive • Bethesda, MD 20817 • Tel: 301-493-0023 • Fax: 301-493-8230
19733 Executive Park Circle •Germantown, MD •Phone 301-540-0445•Fax 301-540-0766
412 First Street SE • Rear Building Lower Level • Washington, DC 20003 • Tel: 202-470-4185 • Fax: 202-741-9952
Email: Contact@nationalspeech.com

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.

National Speech / Language Therapy Center, Inc.

5606 Shields Drive • Bethesda, MD 20817 • Tel: 301-493-0023 • Fax: 301-493-8230
19733 Executive Park Circle •Germantown, MD •Phone 301-540-0445•Fax 301-540-0766
412 First Street SE • Rear Building Lower Level • Washington, DC 20003 • Tel: 202-470-4185 • Fax: 202-741-9952
Email: Contact@nationalspeech.com

Authorization for Release and Disclosure Of Protected Health Information

In accordance with state and regulatory agency requirements, the medical record is the property of National Speech/ Language Therapy Center Inc.

Patient Name: _____ Date of Birth: _____

I hereby authorize that my medical information be released to:

_____
_____

FROM:
National Speech/ Language Therapy Center, Inc.
5606 Shields Dr.
Bethesda, MD 20817
Tel: 301-493-0023 Fax: 301-493-8230

Please release the following information:

☐ Initial Evaluation ☐ Re-evaluation ☐ Progress Notes ☐ Plan of Care

☐ History and Physical ☐ Discharge Summary ☐ Psychological Evaluation

☐ Other (Specify) _____

1. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to National Speech. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

2. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, this authorization will be valid during the duration of treatment.

3. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness