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 20874 • Tel: 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

Welcome to National Speech

Thank you for choosing National Speech to help meet your child's communication needs .We realize there are many options from which to choose and we appreciate the opportunity to assist you with this important process.

The employees at National Speech are consummate professionals who are committed to mutually held values of integrity, service, professionalism, and research-based evaluation/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. We believe in each individual's right to communicate.

This New Client Packet contains very important information about our services, Medicaid and/or insurance company guidelines and regulations, advocacy, and forms you will need to complete prior to evaluation and treatment. Please take time to read all of the information carefully and feel free to ask any questions as you go through this process.

Before scheduling services, completed forms must be turned in to the front office staff or your providing therapist. We must also have a medical referral (that must be updated every 6 months) stating that services are medically necessary on file prior to the first day of therapy. Additionally, please make sure to notify our administrative office if your child is seen elsewhere for any services we are providing. We strive to meet your child's needs and help your child make progress. To do that, we must be kept informed of any therapeutic services your child may be receiving elsewhere that might be duplicating our services. We cannot provide the same service on the same day your child receives the service at any other location.

Therapy is a cooperative effort between our staff and you. Together we can make a difference in your child's life.

We look forward to working with you and your child!

Sincerely,
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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 are generally 30 minutes. The last few 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 Speech 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. In addition, 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 more than one time will result in 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. If you are unable to give the full 24 hours' notice, please call by 9 am the morning of the missed appointment to cancel.

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. We highly encourage rescheduling appointments when you need to cancel. Thank you for your consideration in this situation.

10. National Speech is closed annually on the following 8 dates:
    - New Year's Day
    - Memorial Day
    - Independence Day
    - Labor Day
    - Thanksgiving and the day after
    - Christmas and the day after

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CLIENT INFORMATION

Date completed: _____

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

Name of Person completing this form: _____ Relationship to child: _____

Gender: _____ Prescription for Services? ☐ Yes or ☐ No

Who can we thank for referring you: _____
(Having a prescription/ referral does not guarantee coverage)

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: _____

Would you like for us to email you information regarding upcoming programs, etc.? ☐ Yes ☐ No

Preferred method of contact: _____

What is your child's primary language? _____ Secondary Language: _____

Current concerns/reason for referral: _____

_____

When were you first concerned? _____

_____

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MEDICAL INFORMATION

Physician: _____ Physician Phone #: _____

Diagnosis: _____

Does your child see other medical specialist(s)?

Physician: _____Specialty:_____

Physician: _____Specialty:_____

Other Professional Providers: (occupational, physical or speech therapy, counseling, tutoring, etc): *please list name and contact number .Also please list previous therapies or services your child has received and the approximate dates he/she received them.*

_____

_____

_____

_____

_____

MOTHER'S PREGNANCY AND CHILD'S BIRTH

Please circle *Yes* or *No* to the following questions and remark in the space provided.

1 .Were there any infections/illnesses during pregnancy? ☐ Yes ☐ No _____

2 .Was the pregnancy normal? ☐ Yes ☐ No If abnormal, please specify ._____

_____

3 .Was the delivery normal? ☐ Yes ☐ No If no, please specify ._____
(Cesarean section, breech, sideways, cord around neck, forceps used)

_____

4. What was the child's weight at birth? _____

5 .Were there any complications in the first hours/days/weeks after the child was born? Please specify.

_____

_____

6 .Did the infant have any feeding problems? If yes, please describe. _____

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7 .Please describe any major illnesses or hospitalizations that your child has experienced.

8 .When was your child's most recent hearing exam? _____ Results: _____

9 .History of ear infections: ☐ Yes ☐ No If yes, how many: _____

10 .Does your child have or has she/he had tubes? ☐ Yes ☐ No If yes, please provide information on where and when the tubes were placed:

11 .Are there any diagnosed mental, physical or emotional disabilities? _____

12 .Are there any concerns about physical, sexual, mental or emotional abuse? _____

13 .Describe your child's current demeanor/behavior: _____

14 .Current Medications/Dosage/Frequency: _____

15 .Known Allergies: _____

16 .Known Food Allergies/Restrictions: _____

17 .Are immunizations up to date? ☐ Yes ☐ No

Social/ Educational History

School/Day Care: _____ Grade: _____

Teacher's Name: _____ Phone: _____

Type of Classroom (e.g., Regular education, special education, PEP) _____

1. How is your child doing academically (or pre-academically)?

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2 .Does your child receive special services in school? If yes, describe:

_____

_____

3 .Are there any cultural or religious beliefs that you would like us to be aware of and/or take into consideration when we are working with your child?

_____

_____

Developmental Milestones

Please list the age in months that you child achieved the following:

Crawled _____ Sat up_____ Walked _____ Fed Self _____ Dressed Self _____

Toileted _____ Used Single Words _____ Combined Words _____

1 .Do you feel that your child met his/her developmental milestones on time when compared to peers or siblings?

_____

2. Does your child appear to participate in age appropriate activities (i.e. social/play skills, motor skills, feeding, etc.)?

_____

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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	☐	☐
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:_____

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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 judgement. 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 while they may be observing their own child in a group.

☐ 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

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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.

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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

☐ 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

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PROCEDURE FOR OBSERVING YOUR CHILD IN THERAPY

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

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NOTICE OF PRACTICE POLICIES & FINANCIAL RESPONSIBILITY

- **In the case that insurance therapy sessions and/or evaluations are not covered by the insurance company, the patient is responsible for all charges incurred.**
- **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).**
- **National Speech is happy to accept Maryland Medicaid. Please sign below indicating you understand that your responsibilities, including informing us of any changes in eligibility at any time.**
- **If you change your eligibility status with Medicaid, you are responsible for immediately informing us. If your child is seen and is no longer eligible for Medicaid services, you will be held financially responsible.**
- **Before scheduling services, completed forms must be turned in to the front office staff or to your providing therapist. Additionally, we must also have a medical referral (that must be updated every 6 months) stating that services are medically necessary on file prior to the first day of therapy. Furthermore, it is the parent/caregiver's responsibility to notify our administrative office if your child is seen elsewhere for any services we are providing. Medicaid law states that while we can provide services that are medically necessary for your child, we cannot provide the same service on the same day your child receives that service at any other location.**
- **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.**

I have read and understand the above policies for National Speech/Language Therapy Center.

_____ _____
Signature Date

_____
Printed Name

_____
Child's Name(s)