2024 New Patient Information

To get started with speech and/or occupational therapy services including screening, evaluation, and treatment, we ask that you submit the following preliminary paperwork:

1) A copy of the front and back of the patient's insurance card.
2) Signed copy of the Pediatric Case History Form (separate packet)
3) Signed copy of the New Patient Form (this packet)

You may email or fax the completed paperwork to (prior to first visit):

Speech Center of Katy & Bridging the Gap Pediatric OT

27524 Westridge Creek Lane, Suite A, B, C
Katy, TX 77494
Fax: 832-437-5352

We look forward to working with you to facilitate and improve your child's speech and language/occupational therapy skills. Please do not hesitate to call us at (281) 758-8793 or email us at info@speechcenterofkaty.com if you have any questions.

Consent for Treatment

I agree to allow the Speech Center of Katy to provide speech language pathology and/or occupational therapy services for my child.

In addition:

☐ I agree to attend scheduled therapy sessions (See the Attendance Policy).

☐ I agree to participate in my child or loved one's treatment, as appropriate.

☐ I understand that my child / loved one may be given work to do at home.

☐ I agree to help my child / loved one complete this work to help with treatment goals and therapy plan.

☐ I am aware a copy of my child's evaluation(s) will be sent out to the PCP for review, signature & referral(s) for insurance purposes.

☐ I am aware I will need to provide copies of my medical insurance card(s) & keep the clinic updated with any changes regarding my insurance plan(s)

_____ _____

Print Patient's Name Date

_____ _____

Patient or Parent / Guardian's Signature Relationship to Patient

Consent for Release of Information

I give the Speech Center of Katy with Bridging the Gap OT permission to use or share my child's health information with:

_____

Contact Information: _____

The information that will be used or shared includes (check all that apply):

☐ My medical records

☐ My treatment records (progress notes, daily records)

☐ My speech, language, or swallowing test results

☐ Other: _____

This information is being used or shared because:

_____

This authorization will expire:

On _____ date.

After the following event happens: _____

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time. I need to write to [name of person receiving request] at [address] to do this. Any information that was used or shared before I took back the authorization cannot be returned.

The person or organization that gets my health information because of this authorization may have the right to share it with others without my permission.

_____ _____

Print Patient's Name Date

_____ _____

Patient or Parent / Guardian's Signature Relationship to Patient

Cancellation & Attendance Policy

Thank you for choosing the Speech Center of Katy. We want to provide the best possible services to all our patients. We will do our best to schedule appointments that meet your needs. Regular attendance is important to your/your child's success. We ask thatyou follow the attendance policies outlined below:

1. **Cancellations:** Please give us at least **24 hours** advance notice to cancel your appointment. We reserve the right to charge **the entire service fee of $35.00** if you do not show up for your appointment. Insurance will not cover this fee.
2. **Missed Appointments:** If you cancel or do not attend **3 sessions** in a row, we will put your services on hold until scheduling problems can be worked out.
3. **Late for Appointments:** If you are more than **15 minutes late** for your appointment, we reserve the right to cancel the appointment and consider it a missed appointment (see policy for missed appointments above). If you are late for 3 or more sessions, we may put your services on hold until scheduling problems can be worked out.
4. **Clinician Cancellations:** If the clinician is not able toattend your appointment, you will be contacted as soon as possible. Please be sure that our office knows the best way to reach you. Every effort will be made to reschedule your appointment in a timely manner.

To cancel an appointment, call our office at: **281-758-8793**
or email: **info@speechcenterofkaty.com**

☐ **I agree with the attendance policies outlined above.**

_____ _____
Print Patient's Name Date

_____
Patient or Parent / Guardian Signature

_____
Relationship to Patient

Appointment Reminders

☐ I would like to receive:

- Text Message Reminders:

*Phone Number: _____

*Phone Carrier: _____

And / or

- E-mail Reminders:

*E-mail: _____

☐ I would not like to receive any appointment reminders.

Parent Signature: _____

Date: _____

Photograph & Video Consent

☐ I give my permission for Speech Center of Katy to videotape and / or photograph a therapy / diagnostic session with my child (print name below):

_____

I further understand that portions of the videotape and / or photographs may be used for distribution in educational training materials or on our website for an indefinite period.

☐ I give my permission to videotape and/or photograph a therapy / diagnostic session but opt out of distribution in educational training materials or on the Speech Center of Katy website.

Parent Signature: _____

Date: _____

☐ I do NOT give my permission for Speech Center of Katy to videotape and / or photograph a therapy / diagnostic session with my child for any purpose.

Parent Signature: _____

Date: _____

Consent Form

I understand that: due to the nature of our facility, families are advised that in any given opportunity, you or your child will be exposed to sharing space with other families. Therefore, The Speech Center of Katy with Bridging the Gap requires your consent that if during your child's therapeutic services this may occur.

I understand that: In the effort of providing the best therapeutic approaches, the team of The Speech Center of Katy with Bridging the Gap implements collaborative team approaches. Therefore, The Speech Center of Katy with Bridging the Gap requires of your consent that when given the opportunity, you or your child's name & information will be utilized during staff meetings and/or discussions of therapeutic plans.

Parent Signature: _____

Date: _____

Payment Information

Thank you for choosing the Speech Center of Katy with Bridging the Gap for your speech-language pathology and/or occupational therapy needs. This is an agreement between the Speech Center of Katy and you for payment of services provided. By signing this agreement, you are agreeing to pay for all services provided to you or your family member. Please read the following information carefully.

To bill your insurance for evaluations and treatment, you need to:

- Bring your insurance card and information to your first visit.
- Let the office know if your insurance changes.
- Check with your insurance company before your first visit to find out what speech and language services they will pay for.
- Find out what information the insurance company needs and bring it with you to your first appt.
    - You may need a doctor referral / note, or pre-authorization from your insurer.
    - Referrals and pre-authorizations do not guarantee that insurance will pay for services. Referrals and pre-authorizations do not guarantee that insurance will pay for services.
- Pay all co-pays, deductibles, and non-covered services.
    - We will submit a claim to your insurance company.
    - Co-pays are due at the time of service.
    - If your insurance will not pay for services, you are responsible for the full amount.
    - If your insurance company does not pay us within 14 days, you will be billed for the full amount. If we get paid by the insurance company after that, we will return your payment. *
- Please pay any money owed within 7 days of receiving a bill from our office.

If you do not have insurance and plan to self-pay:

- Payment is due at the time of service. We accept exact cash, checks, cashier's checks, or major credit cards.
- We are happy to talk about other payment arrangements, if needed. Talk to us ahead of time to make payment arrangements. Please don't wait until you are unable to pay to talk with us.

Payment Contact Information

Today's Date: _____

Person Responsible for Payment: _____

Date of Birth: _____ ☐ Male ☐ Female

Preferred Method of Contact:

☐ Phone: _____ ☐ Email: _____

Address (if different from patient address): _____

City: _____ State: _____ Zip: _____

Insurance Payment Information

If your service is covered by insurance, please provide primary medical insurance as well as secondary/tertiary (etc. if applicable):

Primary Insurance: _____

Policy Holder's Name: _____

Policy Holder's DOB:_____

Member ID# : _____

Group #: _____ Phone #: _____

Secondary Insurance: _____

Policy Holder's Name: _____

Policy Holder's DOB:_____

Member ID# : _____

Group #: _____ Phone #: _____

Parents/Guardians are responsible to inform us of any changes with medical insurance throughout the year (ex. Inactive, changing plans, etc).

*** Please include a copy of your 2024 active insurance card(s)***

Mandatory Credit Card Payment Authorization

The undersigned hereby authorizes Speech Center of Katy and Bridging the Gap Pediatric OT, PLLC to charge the below - referenced credit card for services rendered and any related expenses. In addition, I understand my credit card will be charged:

- On the date of service (Saturday patients get charged on the next business day)
- If the invoice is not paid in full on the due date.
- If proper cancellation procedures are not followed as noted in the Cancellation and No-Show Policy.
- If there is a bounced checks returned for insufficient funds , there is a $25 fee.
- At discharge, if an account balance remains, your credit card will be charged for unpaid services to discharge date.

Payment is due at the time of service.

Credit Card on file is mandatory for all patients.

We accept cash (exact change), checks, cashier's checks, or major credit cards.

I, the undersigned, understand it is my responsibility to inform Speech Center of Katy and Bridging the Gap Pediatric OT, PLLC of any changes to my credit card information including address, zip code, updated expiration dates, account numbers and security codes.

Please print clearly below:

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ **CVV Security Code:** _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

_____ _____

Customer Signature Date

Financial Policy

We value you as a client and are committed to providing you or your family member with the best possible speech and occupational therapy care. We want you to have a complete understanding of your financial responsibilities for the services to be provided. To assist us in achieving these goals, we ask that you review our financial policy. Payment in full will be due at the time services are rendered. At the time of the client's appointment, you will be expected to pay your co-pay/co-insurance as well as any portion of the therapy fees that we estimate will not be covered by your insurance policy. Because of insurance policy changes and/or necessary adjustments in treatment plans, the therapy coverage may vary from this estimated treatment calculation or your carrier's pre-estimate.

It is your responsibility to verify coverage and charges with the insurance company, as well as to verify that our office has the correct insurance information including plan information. Be sure to find out what documents your insurance company requires and provide them to our front office before your first appointment.

- You may need a primary care physician's referral / note, or pre-authorization from your insurer.

- Referrals and pre-authorizations do not guarantee that insurance will pay for services.

- Please remember that your insurance is a contract between you and your insurance company and/or employer. Speech Center of Katy with Bridging the Gap Pediatric Occupational Therapy is not a party to the contract.

All therapy charges are the responsibility of the client or responsible party regardless of insurance coverage. The missed appointment fee is not a covered expense of your insurance company. If your insurance company has not paid the full balance of the claim within 30 days from treatment date, you will be responsible for paying the balance. In the event of non-payment, the client or responsible party agrees to pay all the costs of collection including but not limited to attorney fees court costs, collection agency fees, etc.

I have read and understand the financial policy for both Speech Center of Katy with Bridging the Gap Pediatric Occupational Therapy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Parent/Guardian:_____Date:_____

Health Insurance Portability & Accountability Act (HIPAA)

PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Speech Center of Katy is dedicated to ensuring the privacy of your child's speech and/or language evaluation findings and course of therapy treatment. In serving our patients, we create records regarding treatment and services that are provided to have accurate information and ensure the appropriateness and efficiency of treatment services. Federal law requires us to strictly protect any personally identifying information on your child. This notice discloses our policies regarding the storage, use, and sharing of confidential patient information. **Please review this notice carefully.**

Speech Center of Katy and Bridging the Gap Pediatric OT, PLLC is required by law to keep your health information safe. This information may include:

- Notes from your Doctor, Teacher or Healthcare Provider
- Your Medical History
- Your Test Results
- Treatment Notes
- Insurance Information

We are required by law to give you a copy of your privacy notice, called the Health Insurance Portability and Accountability Act, or HIPAA. This notice explains how your health information may be used or shared. Please retain a copy of this notice for your records. We will ask you to sign a page at the end acknowledging that you have been given this notice.

How Your Health Information May Be Used or Shared:

We may use your health information without your permission for the following reasons:

1. **Treatment:** We may share your information with doctors or other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.

2. **Payment:** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for therapy services. This may include sharing important medical information. We may share information to:

a. Get the insurance company's permission to start treatment
b. Get permission for more treatment
c. Get paid for the treatment you receive

3. **Health Care Operations:** We may use and share your health information to run the clinic and make sure all patients receive good care. For example, we may use your health information to:

a. See how well our services are working
b. See how well our staff is doing
c. See how we compare to other clinics and private practices
d. Make our services better
e. Help others study health care services

Your health information may also be used or shared without your permission for:

Abuse & Neglect: We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.

Appointment Reminders: We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by email, or by phone call or voicemail message. If you do not wish to get reminders, please tell your therapist.

As Required by Law: We will share your information when we are told to by federal, state or local law. We will also share information if we are asked by the police or courts.

Government Functions: Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.

I**nformation About a Person Who Has Died:** We may share information with the coroner, medical examiner, or a funeral director, as needed.

Health Related Benefits & Services: We may use your information to let you know of other services that might be of interest to you.

Public Health Risks: We may report information to public health agencies as required by

law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.

Regulatory Oversight: We may use or share your information to report to agencies overseeing healthcare. This may include sharing information for audits, licensure and inspections.

Threats to Health & Safety: Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others.

Worker's Compensation: We will share your information with Worker's Compensation if your case is being considered as a work - related injury.

When your Permission is Needed to Use or Share Your Health Information: You must give us your permission to use or share y our health information for any situation that is not listed on this notice. You will be asked to sign a form, called an authorization, to allow us to share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

Your Privacy Rights Entitle You to:

Ask us not to share your information: You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.

Ask us to contact you privately: You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call you but not email. Or you may want us to call you at work and not at home. You must ask in writing.

Look at and copy your health information: You have the right to see your health information and get a copy of that information at any time. You have the right to see treatment, medical and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.

Ask for changes to your health information: You may ask us to change information that you think is incorrect. You may also ask that we add info that is missing. You must ask us in writing and give a reason for the change. We do not have to make the change.

Get a report of how and when your information was used or shared: You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this:

- You need to ask us in writing.
- You must tell us the dates you are asking about and if you want a paper or electronic copy.
- You may get information going back six (6) years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.

Get a paper copy of this privacy notice:
You can get a paper copy of this notice at any time.

Filing complaints:
You can file a complaint with us or with the government if you think that:

- Your information was used or shared in a way that is not allowed.
- You were not allowed to look at or copy your information.
- Any of your rights were denied.

Who is Covered in this Notice?
The people that must follow the rules of this notice are:

- All speech - language pathologists/therapists, occupational therapists at Speech Center of Katy and Bridging the Gap Pediatric OT, PLLC.
- Anyone who is allowed to add health information to your file, including students and other staff.
- Any volunteers/students/interns who may help you while you are at this clinic / private practice.

Changes to the Information in This Notice
We may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Complaints: You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts: If you have any other questions about this notice or your privacy rights, please ask your therapist.

I have read and understand the privacy policies disclosed in this notice and acknowledge that I have been given a copy of the HIPAA privacy notice.

Print Client / Patient's Name: _____

Child / Patient's Date of Birth: _____

Print Parent's Name: _____

_____ _____

Parent / Guardian's Signature Date