ATLANTA READING &
LANGUAGE THERAPY
LEARN. GROW. THRIVE.

HIPPA POLICY
NOTICE OF PRIVACY PRACTICES
(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Atlanta Reading and Language Therapy is required by law to keep your health information and records safe. This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information maybe used and shared.

□ I acknowledge that I have received a copy of Atlanta Reading and Language Therapy HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

□ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

□ I understand Atlanta Reading and Language Therapy cannot disclose my health information other than as specified in the notice.

□ I understand that Atlanta Reading and Language Therapy reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the client/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: _____

_____ _____

Staff Member Signature Date

Communication Preference Form

Client Name: _____ Date of Birth: _____

In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to me such as clinical documentation, appointment reminders, therapy updates etc. I hereby grant permission to Atlanta Reading and Language Therapy to do the following:

Written Documentation and Verbal Information

□ I grant permission to provide me with written communication via email service. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

□ I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

□ I grant permission to provide me with written communication via USPS in an unmarked envelope.

□ I elect to receive clinical information in person or via telephone through the number provided.

□ I grant permission to leave relevant medical information on my answering machine or voicemail. I also give permission to release medical information pertaining to the client to the individuals listed below:

Sharing of Information

Individual's Name	Relationship to Client	Email Address and/or Phone Number
1.		
2.		

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.

_____	_____
Print Name of Client	Date
_____	_____
Signature of Client or Legal Representative	Relationship to Client

Payment Policy

Thank you for choosing Atlanta Reading and Language Therapy to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Atlanta Reading and Language Therapy for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Atlanta Reading and Language Therapy you are required to carefully review and sign our payment policy.

Please read the following information carefully:

All therapy fees (including session fees and/or co-pays, if applicable) are due:

□ Within 14 days upon receipt of invoice

We accept the following payment methods at this time: **Check or Cash**

Checks should be made payable to **Atlanta Reading and Language Therapy**.

We will provide you with an invoice outlining the services rendered and the amount charged.

Please read and check of all boxes to acknowledge understanding and the sign below:

□ I understand that Atlanta Reading and Language Therapy does not accept private insurance and I am responsible for all costs / fees. I understand that it is my responsibility to seek reimbursement from any third party payer (ex. insurance company, private school, etc.), if I wish to do so. I also understand that Atlanta Reading and Language Therapy will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

□ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

□ I understand that all returned checks will be subject to a $25 returned check fee. Charges incurred and not paid after 30 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

□ I understand that I am responsible for all legal and collection fees, which Atlanta Reading and Language Therapy may incur if payment is not made in accordance with the terms and conditions herein.

□ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 14 days after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds will be issued by check.

□ I, understand that all cancellations require 24 hours notice and that there will be a $100 charge for any cancellations made less than 24 hours. This charge is my sole responsibility and will not be covered by a third-party source.

□ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client Relationship to Client
or Responsible Party

_____ _____
Private Practitioner / Witness Date

Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs are essential for therapeutic success.

While Atlanta Reading and Language Therapy understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows". Please adhere to the following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, or any other event.

All cancellations must be submitted **24 hours** prior to your scheduled appointment.

□ A fee of $100 may be assessed if the following occurs. This fee will be billed directly to the client.

- If cancellations are made less than the required 24 hours.
- If the client fails to show up for a scheduled appointment.

□ If you miss / reschedule / are late for 5 scheduled appointments, the office reserves the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

□ I, _____, understand the attendance / cancellation policy and the risks of not adhering to it.

_____ _____

Print Name of Client Date

_____ _____ _____

Signature of Participant or Legal Representative Relationship to Client

Consent for Services

□ I authorize Atlanta Reading and Language to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by notifying Atlanta Reading and Language Therapy in writing. In addition, Atlanta Reading and Language Therapy may terminate services by notifying me in writing.

□ I do not give my consent or am withdrawing my consent regarding Atlanta Reading and Language Therapy rendering evaluation and therapy services to the client named below.

_____ _____

Print Name of Client Date

_____

Client Date of Birth

_____ _____

Signature of Client or Legal Representative Relationship to Client

Child Intake Form / History

Today's Date _____
Client Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ □ Male □ Female
Diagnosis (if known): _____
Parent(s) / Guardians: _____
Address: _____
City, State, Zip: _____
Phone #1:_____ □ Cell □ Home □ Work □ Other
Phone #2:_____ □ Cell □ Home □ Work □ Other
Email #1:_____ Email #2: _____
Emergency Contact Name: _____
Emergency Contact Relationship to Child: _____
Emergency Contact (Information): _____

Client's Physician: _____
Physician Phone Number: _____
Physician Address: _____

Other Physicians / Specialists Involved In Care:
Referring Physician: _____ Phone Number _____
Physician Address: _____
Secondary Physician: _____ Phone Number _____
Physician Address: _____

How did you hear about Atlanta Reading and Language Therapy?
_____

<u>Family Background</u>
Parent 1 Name: _____ Age: _____
Occupation: _____ Education Level: _____
Parent 2 Name: _____ Age: _____
Occupation: _____ Education Level: _____
Marital Status: □Single □Married □Divorced □Separated □Widowed

What adults does the child live with? Check all that apply:
□Birth Parent(s) □Adoptive Parent(s) □Foster Parent(s)
□Grandparent(s) □Both Parents □Parent 1 Only
□Parent 2 Only □Other: _____

Does the child have siblings or are there other siblings in the home?
Child 1 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 2 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 3 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 4 Name: _____ Age: __ Sex: __ Speech Issues:_____
Child 5 Name: _____ Age: __ Sex: __ Speech Issues:_____

Language(s) are spoken in the home: _____
Who speaks the other language(s)? _____
Describe the child's use/understanding of the language(s): _____
_____

Is there anything additional you would like to share about the family / home environment? _____
_____
_____

Evaluation
Briefly describe why you're seeking therapy by a speech-language pathologist at this time: _____
_____
_____
_____

What are you expecting out of therapy? _____
_____
_____

Has the child had a previous speech, language or feeding evaluation / treatment? □Yes □No By whom: _____
When: _____
Describe the results: _____
_____
_____

Describe in your own words the nature of your concerns about the child's development and/or the primary referral reasons: _____
_____
_____
_____
_____

At what age did you first notice the problem? _____

How do the child's communication difficulties impact the family? _____
_____
_____

If anyone else in the family has a speech or language diagnosis, please describe it: _____
_____
_____

Is the child aware of or frustrated by their communication difficulties? _____
_____
_____

Medical History

Describe any pertinent information about the child's medical history (surgeries, diagnoses, etc.) as well as when they were diagnosed and by whom:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Mother's Health During Pregnancy:

1. Were there any infections or illnesses? □Yes □No
Describe: _____
2. Was there any stress during the pregnancy? □Yes □No
Describe: _____
3. Were there any complications during labor or delivery? □Yes □No
Describe: _____

Child's Health:

1. How many weeks gestation was the child born? __ weeks (40 weeks is typical)
2. The child was _____ lbs ____oz and _____ inches at birth
3. How was the child delivered? □ Vaginally □ Cesarean Section
4. Please describe any complications or concerns during labor or delivery:

_____
_____
_____

Check and describe all that apply:

□ Adenoidectomy Describe: _____
□ Asthma Describe: _____
□ Behavior Issues Describe: _____
□ Brain injury Describe: _____
□ Breathing problems Describe: _____
□ Cardiac issues Describe: _____
□ Chicken pox Describe: _____
□ Diabetes Describe: _____
□ Ear infections Describe: _____
□ Ear tubes Describe: _____
□ Encephalitis Describe: _____
□ Frequent colds Describe: _____
□ High fever Describe: _____
□ Measles Describe: _____
□ Meningitis Describe: _____
□ Mumps Describe: _____
□ Seizures Describe: _____
□ Sensory issues Describe: _____
□ Sleep issues Describe: _____
□ Tongue tie Describe: _____
□ Tonsillitis Describe: _____
□ Tonsillectomy Describe:_____
□ Traumatic brain injury Describe: _____
□ Vision issues Describe: _____

Is the child up to date with immunizations: □ Yes □ No
Please describe: _____
_____
_____

Has the child ever had surgery? □ Yes □ No
Please describe: _____
_____
_____

Has the child ever been hospitalized: □ Yes □ No
Please describe: _____
_____
_____

Has the child ever been in a serious accident? □ Yes □ No

Please describe: _____
_____
_____

Does the child have a chronic illness? If so, please describe: _____
_____
_____

Is the child currently on any medications? If so, please list medication name and reason for medication:
Medication 1: _____
Medication 2: _____
Medication 3: _____
Medication 4: _____

Does the child have any known allergies? □ Yes □ No
Describe: _____
_____
_____

Does the child currently use any equipment? (communication device, walker, etc.) Describe: _____
_____
_____

Does the child have a history of ear infections, tubes, etc. or use hearing aides?
□Yes □No
Describe: _____
_____
_____

Does the child have any known hearing loss? □Yes □No
Describe: _____
_____
_____

If you have any concerns about the child's hearing, please describe: _____
_____
_____

Describe the child's current health status: _____
_____
_____

Is the child currently receiving any of the following services? If yes, please list the person's name and last date of service.

□Developmental Pediatrician _____
□Neurologist _____
□PT _____
□OT _____
□SLP _____
□Behavioral Therapist _____
□Educational Consultant _____
□Psychologist / Psychologist _____
□Vision Therapist _____
□Other: _____

Developmental History

At what age did the child do the following:

Sit alone: _____ Crawl: _____
Stood Up: _____ Walk: _____
Made Sounds: _____ First Word: _____
Combined Words: _____ Sentences: _____
Fed Self: _____ Understood by Others_____
Toilet Trained: _____ Dressed Self: _____

Does the child do any of the following:

□Choke on liquids □Choke on foods
□Avoid foods □Maintain a special diet
□Use a pacifier / suck thumb □Mouth objects
Please describe any of the above: _____
_____
_____

If under 4 years of age, how many words does the child say:
□0-20 □21-50 □51-100 □101-150 □151-300 □301-500 □501+

Does the child produce sentences of the following length:
□2 words □3 words □4 words □5+ words

What percentage of the child's speech do you understand? _____%
How well do people outside of the family understand their speech? _____%

If the child is not using words, how do they communicate? _____
_____
_____

Does the child have any difficulty with the following:

□Attention
□Aggression
□Answering simple questions
□ Understanding people
□ Excessive drooling
□Producing speech sounds
□Reading
□Remembering
□Transitions
□Frustration Tolerance
□Anger
□ Answering –wh questions
□ Following directions
□Chewing or eating
□Stuttering
□School work
□Maintaining eye contact
□Word Retrieval
□Other difficulties: _____

Please describe any of the above: _____
_____
_____

Has the child experienced any difficulty with feeding or swallowing? If so, please describe: _____
_____
_____

<u>Educational History</u>

Is the child currently enrolled in daycare/ school: □ Yes □ No

What is the name of the program? _____

What day(s) do they attend? _____

What is their grade level: _____

Type of classroom: _____

If they receive any accommodations, please describe: _____
_____
_____

Please describe any educational difficulties or learning challenges that this child has faced: _____
_____
_____
_____

Social History

Describe how the child interacts with parents, siblings, or other family members:
_____
_____
_____

Please describe the communication difficulties the child faces in the home environment: _____
_____
_____
_____

Describe any significant events or changes within the home: _____
_____
_____

What are the child's strengths? _____
_____
_____
_____

What are the child's weaknesses? _____
_____
_____
_____

What are the child's favorite activities? _____
_____
_____
_____

Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior? _____
_____
_____

Does the child become easily frustrated with certain activities? If so, please explain: _____
_____

Describe how the child interacts with other children: _____

What are your goals for the child over the next 6 months? _____

What are your goals for the child over the next 5 years? _____

Is there anything else that is important for us to know about the child?

Person filling out the form: _____
Relationship to the child: _____