Aultman Speech Therapy Services, LLC
4805 West 4th Street Hattiesburg, MS 39402
668 Old Salt Rd Sumrall, MS 39482
Phone: 601-270-6968 Fax: 601-336-5255
office@aultmanspeechtherapy.com
www.aultmanspeechtherapy.com

Information & Authorization Form
For
Speech-Language Therapy

Patient's Name:	**Date of Birth:**	**Gender:** ☐ **Male** ☐ **Female**
Guardian's Name/Relation:	**Phone #:** **home:** **cell:**	
Physical Address:	**City/State/Zip:**	
Mailing Address: (If different from above)	**City/State/Zip:**	
Emergency Contact Name and Relation (if above cannot be reached):	**Emergency Contact #:**	

Primary Care Doctor:	**Doctor's Phone #:**
Insurance Company Name:	**Insurance Policy #:**
Insured's Name: (If private insurance)	**Insured's Date of Birth: (If private insurance)**
Insured's Employer: (If private insurance)	

Does your child already receive speech/language therapy? □ No □ Yes

Does your child have an IEP? □ No □ Yes If yes, with whom?

Authorization of Services

I hereby authorize Aultman Speech Therapy Services, LLC's Speech-Language Pathologists and Speech-Language Pathology Aides to screen, evaluate, and treat the above named patient as the need is indicated by his/her attending physician. I authorize Aultman Speech Therapy Services, LLC to request and/or release Protected Health Information including medical records, treatment records, diagnostic records, and IEPs as necessary to individualize therapy and/or obtain insurance prior authorization. This includes but is not limited to physicians, teachers, other school representatives and other therapists. I also authorize Aultman Speech Therapy Services, LLC to take photographs of above named patient if needed to be used as part of his/her Protected Health Information that may be released as indicated above.

_____ _____

Signature of Parent or Legal Guardian Date

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SPEECH THERAPY INFORMATION REQUEST

Beneficiary Name: _____ Date of Birth: _____

Clinical Speech Therapy Provider: **Aultman Speech Therapy Services, LLC**

Educational Agency: _____

I give consent for the educational agency listed above to release information regarding my child to the above named clinical speech therapy provider.

_____ _____
Parent or Legal Guardian Signature Date

***Educational Agency fills out below this line:**

The above named beneficiary does **NOT** have an Individualized Education Plan (IEP) in place at this time because (please check one of the following):

☐ Child has been referred to his/her local school district for testing but a comprehensive evaluation has yet to be scheduled by the school district.

☐ Child has been referred to his/her local school district for testing and a comprehensive evaluation has been scheduled for ____/____/_____.

☐ Child was screened by his/her local school district on ____/____/_____ but did not qualify for further testing by the school district.

☐ Child was evaluated by his/her local school district on ____/____/_____ and qualified for educational services; however, the parent did not consent to placement in the speech/language program and has chosen to receive services elsewhere.

☐ Other: _____

_____

*By signing below, I hereby attest that the above information is true and accurate.

_____ _____
School Representative Signature/Title Date

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Communication Authorization

Patient Name: _____

Patient Date of Birth: _____

Parent/Legal Guardian Name (Printed): _____

Email address: _____

Cell phone #: _____

* I authorize Aultman Speech Therapy Services, LLC to send a **Patient Portal** email to the above email address. Once you receive the email, you will set your password using the link provided. (The email address listed above is your user name.) **Save the link to access the secure Patient Portal** for access to your child's Speech Therapy records (Protected Health Information) which can be used for personal viewing or to share with others needing his/her therapy records.

* I authorize Aultman Speech Therapy Services, LLC to email and/or text information regarding appointments, home exercise programs, and other information as needed. Emails and/or texts will be general and will not include any Protected Health Information.

-If home exercise programs, appointment reminders, etc. need to go to a different email/text than listed above (ex. other parent, grandmother, aunt, sitter), please indicate in the space below the person's name, relationship and email and/or cell #.

Parent/Legal Guardian Signature: _____ Date: _____

*By signing above, I affirm that I am the parent or legal guardian of the above named patient.

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Teletherapy Informed Consent Form

(1) As defined by ASHA, "Teletherapy" or "Telepractice" is the application of telecommunications technology to the delivery of speech language pathology professional services at a distance by linking clinician to client for assessment, intervention, and/or consultation via interactive audio, video, or data communications. I understand that teletherapy can involve the communication of my medical/health information, both orally and/or visually.

(2) Teletherapy will occur in the state of MS (USA) and will be governed by the current laws of the state as applicable. I understand that the teletherapy services received will be the equivalent in quality of face to face sessions as mandated by *ASHA's Code of Ethics* and *Scope of Practice in Speech-Language Pathology.*

(3) The current laws that protect the confidentiality of my medical information also apply to teletherapy at the time of service rendered. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session unless agreed upon, or as deemed necessary for treatment.

(4) I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

(5) In the event our teletherapy is not in my best interests, my speech-language pathologist will explain that to me and suggest some alternative options better suited to my needs.

(6) I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my SLP, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

(7) I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location within my home with sufficient lighting and privacy that is free from distractions or intrusions during my session.

I have read, understand, and agree to the information above.
I hereby grant consent to engage in teletherapy with Aultman Speech Therapy, LLC.

_____
Patient's Name

_____ _____ _____
Signature of Parent or Legal Guardian | Date | Phone number

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SIGNATURE of ACCEPTANCE and ACKNOWLEDGEMENT

Insurance Authorization Policy

I, the undersigned, authorize payment of medical benefits to Aultman Speech Therapy Services, LLC for any service rendered to the patient by the Speech-Language Pathologist. I understand that I am financially responsible for any amount not covered by my insurance policy. I also authorize you to release my insurance company information concerning healthcare, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
**I understand that it is MY responsibility to watch my EOB (Explanation of Benefits) from my insurance for the amount "owed to provider." I understand and agree to pay the amount owed. I understand it is my responsibility to contact Aultman Speech Services, LLC for any questions regarding insurance.

_____ _____

Signature Date

Privacy Policy

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand. I give consent to Aultman Speech Therapy Services, LLC to use and disclose protected health information about the patient for treatment, payment, and healthcare operations.

_____ _____

Signature Date

Financial Policy

I have been provided a copy of the Aultman Speech Therapy Services, LLC Financial Policy. I understand that I, the patient or patient's representative, am responsible for payment of all charges for services rendered including what is not covered by insurance (co-pays, deductible, co-insurance, etc). I also acknowledge that non-payment of my account may result in dismissal from treatment. **I agree to make monthly payments on any balance owed. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

_____ _____

Signature Date

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Financial Policy

- **Payment:** Payment is due when services are rendered, however we do allow monthly payments as long as payments are being made. If insurance is being filed, you will be responsible for any co-pay, co-insurance and deductible amounts. It is your responsibility to watch your EOB (Explanation of Benefits) from your insurance for the amount "owed to provider." It is also your responsibility to contact your insurance company and/or Aultman Speech Therapy Services, LLC if have any questions. If payments are not being received on a timely basis, services may be discontinued permanently or until the payments are caught up. In the event your account is turned over to collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

- **Authorizations:** Some insurance plans require a prior authorization for services. Aultman Speech Therapy will attempt to obtain prior authorization, if denied, we will go through the appeal process one time at which point you will be responsible for obtaining prior authorization.
Medicaid requires a doctor's visit **EVERY 6 months to be approved for services.

- **Participating Insurance Plans:** If Aultman Speech Therapy does not participate in your insurance plan, you will be responsible for filing your own claims and paying in full at the time service is rendered.

- **Non-covered services/denied charges:** Certain services may be considered non-covered services or may be denied as not medically necessary by your insurance carrier. If your physician feels these services are needed and they are performed, you are obligated to pay for these services in full should your insurance carrier deny payment.

- **Cancellation/"No Show" Policy:** Please notify your therapist as soon as possible if you will be unable to keep your appointment. Failure to show up for three consecutive appointments with no prior notice may result in dismissal of services.

- **Insurance policy changes:** If you obtain an additional policy or switch your current insurance company or make changes to your policy, please notify Aultman Speech Therapy as soon as possible. Failure to notify Aultman Speech Therapy of changes could result in extra charges to you.

- **Termination of Services:** Notify Aultman Speech Therapy if you choose to terminate services. You will be responsible for payments of all services until the date we are notified.

****Parent/Guardian Copy****

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Privacy Policy

Objective

Aultman Speech Therapy Services, LLC has adopted a policy that protects the privacy and confidentiality of protected health information (PHI) whenever it is used by company representatives. The private and confidential use of such information will be the responsibility of all individuals with job duties requiring access to PHI in the course of their jobs. You may request a detailed copy of our HIPAA Notice of Privacy Practices Policy.

Protected Health Information (PHI) Defined

PHI refers to individually identifiable health information, including but not limited to demographics, medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.

The HIPAA Privacy Compliance Officer

Aultman Speech Therapy Services, LLC has a designated HIPAA compliance officer (HCO), and any questions or issues regarding PHI should be presented to the HCO for resolution. The HCO is also charged with the responsibility for:

- Issuing procedural guidelines for access for PHI.
- Developing a matrix for personnel who will need access to PHI.
- Developing guidelines for describing how and when PHI will be maintained, used, transferred or transmitted.

Annual Activities Necessitating Use of PHI and Your Rights under the HIPAA Privacy Rule

Annually or more frequently as necessary, Aultman Speech Therapy Services, LLC provides assistance in insurance claims problem, resolution, and explanation of benefits issues; assists in coordination of benefits with other providers; update medical records as needed. Some or all of these activities may require the use or transmission of PHI. Thus, all information related to these processes will be maintained in confidence, and employees will not disclose PHI from these processes for employment-related actions, except as provided by administrative procedures approved by the HCO. General rules follow:

- Disclosures that do not qualify as PHI-protected disclosures include:
  - Disclosure of PHI to the individual to whom the PHI belongs.
  - Requests by providers for treatment or payment.
  - Disclosures requested to be made to authorized parties by the individual PHI holder.
  - Disclosures to government agencies for reporting or enforcement purposes.
- Information regarding whether an individual is covered by a plan for claims processing purposes may be disclosed.
- Information is being furnished for claims processing involving workers' compensation, ADA or FMLA status.

You have a right to request in writing a copy of your PHI unless otherwise prohibited by federal law.

Records Retention

Personnel records and disclosures of PHI will be maintained for a period of six years as required by federal law, unless a state law requires a longer retention period. Records that have been maintained for the maximum interval will be destroyed in a manner to ensure that such data are not compromised in the future in accordance with the company record destruction policy.

****Parent/Guardian Copy****