Aultman Speech Therapy Services, LLC
4805 West 4th Street Hattiesburg, MS 39402
668 Old Salt Road Sumrall, MS 39482
Phone (601)270-6968 • Fax (601)336-5255
www.aultmanspeechtherapy.com

Dear parent/Guardian,

It's that time of year again! We are looking forward to beginning a new school year and continuing to work with your child to improve his/her speech/language/literacy skills. Please fill out and sign the following pages so that we may update our records and continue providing therapy services to your child. Feel free to contact the office with any questions or concerns.

Thank You,
Aultman Speech Therapy Services, LLC

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Information & Authorization Form Update
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/Relation (if above cannot be reached):	**Emergency Contact #:**	
Email Address:		

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/give permission to 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 IEP's as necessary to individualize therapy and obtain insurance prior authorization. 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 to his/her attending physician.

Guardian Signature: _____ Date: _____

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SPEECH THERAPY INFORMATION REQUEST

Beneficiary Name: _____ Date of Birth: _____

Medicaid ID number: _____

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 Signature Date

The above named beneficiary does NOT have and 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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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.

_____
Client's Name

_____ _____ _____
Signature of Guardian Date Phone number

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Patient Portal Access Request Form:

Patient Name: _____

Patient Date of Birth: _____

Email address: _____

Parent/Guardian Signature: _____ Date: _____

By signing above, I affirm that I am the legal parent or guardian of the above named patient. I also authorize Aultman Speech Therapy Services, LLC to send a Patient Portal Login email to the above email address. I understand this secure Patient Portal will give me access to my child's Speech Therapy records (Protected Health Information).

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SIGNATURE of ACCEPTANCE

Insurance Authorization

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.

_____ _____

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. I also acknowledge that non-payment of my account may result in dismissal from the practice.

_____ _____

Signature Date

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Financial Policy

- **Payment:** Payment is due when services are rendered. If insurance is being filed, you will be responsible for any co-pay, co-insurance and deductible amounts at the time of service. If you are unable to pay these amounts at the time of service, your appointment may be rescheduled.

- **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.

- **Participating Insurance Plans:** If Aultman Speech Therapy does not participate in your insurance play, 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 the speech-language pathologist 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.

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.

12/17 Revised

Parent/Guardian Copy