1515 Johnson Ferry Road
Suite 100
Marietta, Georgia 30062
Phone: (770) 977-9457
Fax: (770) 977-5087

Greater Atlanta Speech and Language Clinics

Working Together for a Greater Tomorrow

Mindy C. Elkan, M.A., CCC
Clinical Director
Michelle Needle, M.Ed.,CCC
Assistant Director

For Clinic Use: Therapist Name: _____ **Evaluation Date:**_____ **Therapy Day/ Time** _____

PATIENT INFORMATION

Please complete the following information for <u>all</u> patients (please print legibly):

Patient Name: _____
(Last • First • Middle)

Address**:**

_____
City State Zip

Sex: □ M □ F Age: _____ Date of Birth: _____/_____/_____Patient SS#: _____

<u>If patient is a child</u>, please complete the following:

Name of Parent #1: _____ Email: _____

Home #: _____ Cell #: _____

Address (if different from child): _____

Employer & Address: _____

Name of Parent #2: _____ Email: _____

Home #: _____ Cell #: _____

Address (if different from child): _____

Employer & Address: _____

Marital Status of Parents: □ Single □ Married □ Widowed □ Separated □ Divorced

If parents are divorced, separated, or unmarried, please fill out this section:

Who has physical custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to treatment for the child or from obtaining information about the child's treatment? YES/NO

If yes, please explain and provide a copy of any legal paperwork that supports this restriction:

_____

<u>Adult patients</u>, please complete the following:

Email: _____

Home #: _____ Cell #: _____

Employer & Address: _____

Name of Spouse (if applicable): _____Spouse's Employer: _____

Thank you for trusting us with your therapy needs. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call.

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CONSENTS

1. Consent to Treat
I consent for therapists employed by GASLC and/or contracted therapists working for GASLC to provide my child or myself with speech-language, occupational, and/or physical therapy including assessment and intervention. Yes_____

2. As the parent or legal guardian of the patient, I give authorization for the person(s) named below to bring my child to the evaluation/therapy sessions in my absence. I also give permission for the therapist to discuss the current treatment procedures and/or release records to the people listed below. This is in compliance with HIPAA 1996 and is designed to safeguard the privacy and security of the named patient's health information.

Parent #2: YES/NO

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

3. Consent to Email Protected Health Information
I consent for employees and contracted therapists working for GASLC to send any and all protected health information regarding my child or myself via email, which includes but is not limited to: evaluations, treatment notes, weekly session updates, progress notes, etc.

Yes _____ No_____

4. Photo Release:
I give permission for my child's picture to be used on our bulletin boards, website, and Facebook. Yes _____ No_____

5. Cancellation/Termination Policy:
GASLC reserves the right to charge a fee for any appointment that is not kept or not cancelled by giving 24 hours notice. Unforeseen circumstances are anticipated and will be handled on a case by case basis. If you plan to dismiss your child or yourself from therapy, a 2-week notification is REQUIRED unless otherwise agreed upon. Should you choose to end treatment without two-week notification, you will be responsible for paying for all services that would have been provided in those two weeks. Initialing below notifies GASLC that I agree to the above cancellation and termination policies.

Initial Here _____

PHSYICIAN INFORMATION

Patient's Physician's Name: _____

Address: _____ _____
City State Zip

Physician's Phone #: _____ _____

Whom may we thank for referring you: _____

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FINANCIAL RESPONSIBILITY INFORMATION

Who is the responsible party for this account? _____ Relationship to Patient: _____

Date of Birth of Responsible Party: _____ SS# of Responsible Party: _____

INSURANCE/MEDICAID INFORMATION

If patient is covered by insurance complete the following information:

Insurance Company: _____ID & Group #: _____

Primary Insured/Subscriber Name: _____Relationship to Patient: _____

Date of birth of primary insured: _____ SS# of primary insured: _____

If patient is covered by Medicaid complete the following information:

Medicaid #: _____ Deeming Waiver?_____ SSI? _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Greater Atlanta Speech and Language Clinics, Inc.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Greater Atlanta Speech and Language Clinics, Inc.** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Responsible Party Relationship to Patient Date

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FINANCIAL POLICY

Thank you for choosing Greater Atlanta Speech and Language Clinics, Inc., (GASLC, Inc.) to provide your speech, occupational and/or physical therapy. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

Our practice is committed to providing the best treatment possible for our patients and we charge with what is usual and customary for our area.

WE ACCEPT PAYMENTS BY CASH, CHECKS, AND MOST MAJOR CREDIT CARDS.

GASLC, Inc. regards the adult party who signs below as "Parent or Responsible Party" to be the responsible guarantor for that patient's account in all cases and without exception.

We are considered in-network for the following insurance companies: Cigna, United Healthcare, Blue Cross/Blue Shield, Aetna, and Coventry. Although we are considered to be in-network with your insurance carrier, this is not a guarantee of coverage or payment for our services. We also accept Deeming Waiver and Medicaid for children up through age 21.

Your co-pay/coinsurance amount is expected at each visit. Please be aware that some and perhaps all of the services provided may be "non-covered" services with your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

All insurance claims following treatment at Greater Atlanta Speech and Language Clinics (GASLC) are filed as a courtesy to you and are subject to review by your insurance carrier. **GASLC will submit a claim with your insurance carrier up to 2 times per appointment and any further insurance appeal is solely your responsibility unless a secondary source of payment is established.** This includes, but is not limited to: insurance denial of coverage, policy deductibles, policy maximums, annual or lifetime benefits being exceeded, and GASLC not receiving payment within a reasonable amount of time even if you are in an appeals process with your insurance carrier. _____Client/Parent Initials

In the event your insurance company denies coverage, ***you will be responsible for payment of all charges*** and we require the balance of the account on the first of every month. *Please be advised that if we are filing with a private insurance company that it can take up to 30-60 days or longer to receive an EOB (explanation of benefits). By the time we know whether or not your insurance company will pay, you may have accumulated more than one month's invoice.* ***Please plan ahead as you will be expected to pay the balance on all of the invoices by the first of the following month.*** _____Client/Parent Initials

A request for preauthorization DOES NOT guarantee approval of coverage, and coverage is not retroactive. Should you prefer to begin services and pay privately while preauthorization is being pursued, you may do so. All payments must be made at time of services rendered and are not reimbursable by insurance if approved. _____Client/Parent Initials

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You are responsible for keeping track of your number of covered visits per calendar year. If you exceed the maximum number of visits as provided by your insurance coverage, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL. _____Client/Parent Initials

GASLC, Inc. will exercise the right to charge 10% interest on past due accounts. This will accrue each 30 days the account is overdue. Additionally, there may be a $10 late processing fee per month.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the above Financial Policy and understand and agree to abide by this policy.

_____

Signature of Parent and/or Responsible Party Name of Client (Print) Relationship to Client Date

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***Please complete if GASLC is billing your insurance company

CONSENT TO RELEASE CONFIDENTIAL INFORMATION FOR INSURANCE PURPOSES

I authorize the release of any medical or other information that is necessary to process claims or approve therapy treatment to my insurance company (such as initial evaluations, progress reports, clinical notes, including evaluations from other clinics or schools):

I authorize GASLC to release the following information from other facilities to my insurance company (only as requested by the insurance company):

1. _____

2. _____

3. _____

Name of insurance company: _____

Signed: _____ Date: _____
(Parent/Guardian/Insured)

Name of Patient: _____

I authorize payment of medical benefits directly to Greater Atlanta Speech and Language Clinics, Inc., for services

rendered to _____
(name of client)

Signed: _____ Date: _____
(Parent, Guardian, Insured)

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***Please complete only if you would like your reports and/or records sent to a third party

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

The undersigned authorizes Greater Atlanta Speech and Language Clinics, Inc., to release pertinent information (initial evaluation report, progress reports, clinical notes) to:

_____	_____
Physician/School/Facility Name	Physician/School/Facility Name
_____	_____
Address	Address
_____	_____
Address	Address
_____	_____
Phone/Fax	Phone/Fax

when such information is necessary in the therapeutic program of the patient.

_____	_____
Patient Name (Print)	Parent/Guardian/Patient (Signature)

_____
Date

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***Please complete only if you would like GASLC to obtain your records from another facility

CONSENT TO REQUEST CONFIDENTIAL INFORMATION

To: _____
(Agency, school, physician, etc.)

Address: _____

_____

_____

Re: _____

The undersigned authorizes Greater Atlanta Speech and Language Clinics, Inc., to request the following information you have concerning the above patient:

☐ a. Copies of all therapy services including notes, clinical evaluations, etc.
☐ b. Copies of all education reports
☐ c. Copies of all medical and hospital reports
☐ d. Other: _____

_____

_____

Signed: _____ Date: _____
(Parent/Guardian/Client)

Witness: _____

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Medical History and Seizure Treatment Plan

*****Please complete if applicable and a history of seizure disorder is present**

Name: _____
Parents Names: _____
Parents Contact #s: _____
Doctor's Name and #s: _____
Date of Birth: _____Age: _____Weight: _____
Seizure Type: _____
Description of seizure: _____
_____
_____
Seizure Triggers: _____
Current Seizure Medication: _____
Allergies: _____
_____
Medical History: _____
_____
_____
_____

Treatment Order:

_____
_____
_____

Basic First Aid for Seizures

1. Put in recovery position (turn on side and keep airway clear)
2. Cushion head, remove glasses
3. Loosen tight clothing
4. Note the time a seizure starts and the length of time it lasts
5. Don't put anything in mouth
6. Don't hold down
7. As seizure ends, offer help and reassure patient

For Office Use Only

- **Medication Name:** _____
- **Location of Medication**: _____
- **Dosage of Medication:** _____

Other Notes: _____
_____
_____
_____

Acknowledgment of Receipt of Privacy Practices

I, _____ have received a copy of **Greater Atlanta Speech & Language Clinics, Inc.'s** Notice of Privacy Practices with an effective date of April 14, 2003.

Name of Patient: _____

Address of Patient: _____

_____

Signature of Patient _____ Date _____
(Or Parent/Guardian of Patient)

Name of Witness: _____

Signature of Witness _____ Date _____

Notice of Privacy Practices

April 14, 2003

Greater Atlanta Speech & Language Clinics, Inc.

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, 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.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

• **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include speech, occupational, or physical therapy services, etc.

• **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical plan for your therapy services.

• **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 include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

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 certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:
• The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, 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 request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
• The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
• The right to request an amendment to your PROTECTED HEALTH INFORMATION.
• The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
• The right to obtain a paper copy of this notice from us upon request.

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.

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. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
The Clinical Director
Mindy C. Elkan, M.A., CCC
Greater Atlanta Speech & Language Clinics, Inc.

☐ 1515 Johnson Ferry Road, Ste. 100

Marietta, Georgia 30062

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For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)