Alliance
Speech & Language Center

Dear

Enclosed please find the necessary paperwork that needs to be completed for your Speech Evaluation, which I scheduled for,

Your insurance requires our office to have a script from your primary care physician on file for this evaluation. Please be sure to bring the script with you on the day of your visit, should your insurance require a referral, please bring that as well.

We will be contacting you a week prior to your evaluation to confirm the appointment.

Thank you

Staff

Alliance Speech & Language Center

4691 Highway 9 North, Howell, NJ 07731
Phone: (732) 942-7220 Fax: (732) 942-7225
aslhowell@gmail.com

Shira Kirsh, MS, CCC-SLP, COM
Speech Language Pathologist
Certified Orofacial Myologist
www.njspeechandlanguage.com
shirakirshslp@gmail.com

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PATIENT INFORMATION

Name: _____ DOB: _____/___/_____ Age: _____
Address: _____
Street Apt# City State Zip
Home Telephone: _____ Employer Name: _____
Cellular Telephone: _____ Employer Address: _____
E-mail address: _____ _____
Health Insurance Company: _____
Policy Holder's Name: _____ Policy Holder's Date of Birth: ___/__/__
If patient is a minor:
Mothers Name: _____ Fathers Name: _____
Who is your primary care physician? _____Phone:_____
(If you would like a copy of your test results forwarded to your physician, please sign the release below)

Who referred you to our office?

We like to know how our patients find our practice. If your physician, a family member, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful that we know. If it is your physician, audiologist, family member, or friends, please provide their name.

____Physician ___Health Plan ___Newspaper Ad/Article __Our Website __Facebook __Twitter __Instagram
____Other Professional _____
____Word of Mouth _____
(Please provide the name of any specific person that referred you to our office)

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Alliance Speech & Language Center for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself. Financial Responsibility: I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered and that my payment is expected at the time of service. This includes, but is not limited to co-insurance, co-payment, and no-covered services. I promise to pay all costs of collection including reasonable attorney's fees and collection agency costs that may incurred in the collection and any indebtedness due to Alliance Speech & Language Center

_____ _____/____/_____
Patient/Parent/Guardian Signature Date

Release of Medical Information

_____, hereby authorize Alliance Speech & Language Center to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed about I would also like to have this information forwarded to:

_____

_____ ____/___/_____
Patient/Parent/Guardian Signature Date

Acknowledgement of receipt of Notice of Privacy Practices

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practice (HIPAA)

_____ _____/_____/_____
Patient/Legal Guardian/Parent Signature Date

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INSURANCE APPROVAL

As per some insurance policies, a pre-certification will be needed prior to paying for speech treatment. We will submit all of the required paperwork and work with you and your insurance company to get the services covered. However, it is YOUR responsibility to get involved with this process since the contract is between you and your insurance company. Because of this, you are liable for receiving approval and payments from your insurance company.

SHOULD YOUR INSURANCE COMPANY DENY PAYMENT FOR ANY REASON, YOU WILL THEN BE RESPONSIBLE FOR ANY NON-COVERED SERVICES.

Thank you in advance for your cooperation. Please sign below to acknowledge that you have received, read and fully understand this notice.

_____ _____

Patient or Guardian Signature Date

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CANCELLATION AND TERMINATION POLICY

New Clients:

We require a $100 refundable deposit for all evaluations. You may provide a check or your credit card number to hold your appointment. There is a 48-hour required notice of cancellation for Speech Evaluations, subject to a $100 fee, except for extenuating circumstances such as illness. In the case of scheduling conflicts, we will only reschedule an evaluation one time.

Current Clients:

There is a 24-hour notice required for cancelled appointments. If a patient or guardian does not provide proper notification, they will be subject to a $100 fee. Extenuating circumstances will be considered, at the discretion of our office.

When a client *does-not-show* and *does-not-call* two consecutive times for scheduled treatment sessions, they will be terminated from treatment, and not be admitted back into our practice. A letter to notify them of the termination of treatment will be sent.

When clients show up 15 minutes late for their scheduled treatment or evaluation session the appointment will be treated as a *no-show* and they will be responsible for the missed appointment fee. When they show up less than 15 minutes late, the session will end at the scheduled time, unless there is time to extend the session, at the discretion of the treating therapist.

Consistent attendance is very important to the success of each client's treatment program. When a client calls the same day to change their appointment for earlier or later that day, we will try our best to accommodate them. Otherwise they are subject to the missed appointment fee. If a client anticipates in advance, a missed appointment due to a conflict in their schedule, they should make every effort to reschedule for another appointment the same week, especially if their appointment is late in the week. Please make arrangements as early in the week as possible. We can also contact you if we have any openings that come up which may be more convenient for you. Our after-school appointments are usually fully booked, and if someone cancels well enough in advance, it may allow someone else who needs to reschedule their appointment for that timeslot, an opportunity to do so.

We ask that clients do not miss more than 1 visit each month if scheduled for 1 visit weekly, or not more than 2 visits each month if scheduled for 2 visits weekly, except for illness or extensive travel. We have the right to remove clients who cancel chronically, without legitimate reasons, from the schedule.

_____ _____ _____

Print Patient/Guardian Name Signature Date

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Consent for Photography

Patient Name_____ DOB: _____

Parent or Legal Guardian: _____

I consent to have my (or child or an individual to whom I provide guardianship) image to be taken by the staff at _____as described below.

I understand that my (or child or an individual to whom I provide guardianship) photographs, videotapes, digital, and other images may be recorded to document and assist with my care and the payment of my care (or child or an individual to whom I provide guardianship). These images may be used to assist in the evaluation of the patient. I understand that Alliance Speech & Language Center will own these images, but that I will be allowed access to view them or obtain copies of them at a reasonable cost. Other than for treatment and education purposes, images that identify me (or child or an individual to whom I provide guardianship) will be released and/or used outside the organization only upon written authorization from me or the patient representative.

Purpose of the disclosure for any purpose other than treatment of education purposes:
_____

Dates of Treatment: From: _____ To: _____

I may revoke or withdraw this consent at any time. Unless revoked earlier, this consent expires in **one** year unless I specify another time period: _____.
Withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or New Jersey privacy regulations.

I release and hold harmless Alliance Speech & Language Center, its staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the photograph or other images.

By signing below, I am indicating that I have read and understand the “Consent for Photography” form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

_____ _____
Patient or Patient Representative Signature Date

_____ _____
If Patient Representative, Relation to Patient Printed Name

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Dear Patient,

It is the policy of this practice that we keep a copy of an active credit card of yours on file, in case of monies owed to us. Some examples may include: if your insurance company's EOB lists you as responsible for any portion of the bill, and if borrowed materials are not returned to us. This may include special CD's books, or electronic equipment.

By signing the following waiver, you are allowing us to bill your credit card on file, should the above situations arise.

I _____agree to allow charges to be placed on my credit card for services rendered.
(Patient or Guardian)

_____
(Date)

Credit Card Company: MC
Visa
AMEX
Discovery
Other _____

Number _____

Expiration _____ /_____

Security Code _____

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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.

Alliance Speech & Language is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at **Alliance Speech & Language** please contact: Shira Kirsh.
4691 Route 9 North Howell, NJ 07731
732-942-7220

Effective Date of this Notice: February 1, 2005

I. How **Alliance Speech & Language** may Use or Disclose Your Health Information **Alliance Speech & Language** collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of **Alliance Speech & Language,** but the information in the medical record belongs to you. **Alliance Speech & Language** protects the privacy of your health information. The law permits **Alliance Speech & Language** to use or disclose your health information for the following purposes:

1. Treatment. If another treatment provider is treating you, we may discuss your case in order to coordinate care between us. The kinds of health care information we may disclose about you in such circumstances could include your diagnosis, hearing test results, etc…
2. Payment. If you are covered by health insurance we may disclose diagnostic treatment details to your insurance provider in order to obtain payment for services rendered.
3. Regular Health Care Operations. An example of regular health care operations that can occur would be: your medical records may be randomly inspected by people who conduct quality assurance reviews to ensure that high standards or care are being maintained.
4. Information provided to you. You have the right to access your health information by completing a request for patient access to health information form.

5. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for you care about you location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
6. Required by law. As required by law, we may use and disclose your health information.
7. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to : preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications: and reporting disease or infection exposure.
8. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
9. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.
10. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
11. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.
12. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
13. Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or **Alliance Speech & Language** privacy board.
14. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
15. Specialized government functions. We may disclose your health information for military, national security, prisoner and government benefits (only for health plans) purposes. (Note that disclosures for government benefits purposes are limited to health plans only.)
16. Worker's compensation. We may disclose you health information as necessary to comply with worker's compensation laws.
17. Marketing. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.
18. Change of Ownership. In the event that **Alliance Speech & Language** is sold or merged with another organization, your health information/record will become the property of the new owner.

II. When **Alliance Speech & Language** May Not Use or Disclose Your Health Information Except as described in this Notice of Privacy Practices, **Alliance Speech & Hearing** will not use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

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III. Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. **Alliance Speech & Language** is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at an alternative location. (This requires requests in writing; specification of method; payment for method, as applicable.)
3. You have the right to inspect and copy your health information.
4. You have a right to request that **Alliance Speech & Language** amend your health information that is incorrect or incomplete. **Alliance Speech & Language** is not required to change your health information and will provide you with information about Professional Audiology Associates' denial and how you can disagree with the denial.
5. You have a right to receive and accounting of disclosures of your health information made by Alliance Speech & Language, except that Alliance Speech & Language does not have to account for the disclosures described in parts 1 (Treatment), 2 (Payment), 3 (heath care operations), 4 (information provided to you), 5 (directory listings and 16 (certain government functions) of sections I of this Notice of Privacy Practices.
6. You have a right to a paper copy of the Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact:

Shira Kirsh. 4691 Route 9 North Howell, NJ 07731
732-942-7220

IV. Changes to this Notice of Privacy Practices
Alliance Speech & Language reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, Alliance Speech & Language is required by law to comply with this Notice. Revised Notice of Privacy Practices will be displayed in the waiting room when amended as well as the patient will be notified at time of visit.

V. Complaint
Complaints about this notice of Privacy Practices or how Alliance Speech & Language handles your health information should be directed to:

Shira Kirsh 4691 Route 9 North Howell, NJ 07731
732-942-7220

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Department of Health and Human Services Office of Civil Rights Hubert H. Humphrey Bldg. 200 Independence Avenue, S.W. Room 509F HHH Building Washington, DC 20201