LEAPS IN LANGUAGE
"ACHIEVING SPEECH, LANGUAGE AND ACADEMIC SUCCESS"

Dear Client,

Welcome to our clinic! We are glad you have chosen Leaps in Language for your Speech/Language, Tutoring and/or Consultation needs. We know that you have many choices when choosing a professional, and we do not take your decision to choose our clinic lightly. We are dedicated to providing quality, caring and professional attention to each of our families. We are sure that you will be satisfied with the exemplary services you will receive from us.

Our programs are individually designed to meet our client where they are. We build specific therapy and/or academic plans for each individual. Our goal is to provide the highest quality therapy in a personable, caring environment. We provide whole family education to help our clients & families succeed long after they leave our care.

Attached is an information package that lets you know about us and will help us learn about you and your needs. Please review all the information in its entirety before completing the forms.

Once you have completed all forms please return them to our office along with the following:

- Copy of Insurance Card
- Signed Physicians Order Form
- Copy of most recent Speech/Language Therapy evaluation (if you have it).
- Copy of current or most recent IFSP or IEP.
- Copy of medical necessity from your doctor if required by your insurance.
- Copy of any medical and/or psychological evaluations pertaining to the diagnosis of your child/family member.

Thank you,

The Leaps in Language Team

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New Client Intake Form

Date: _____ **D.O.B**: _____ **SSN:** _____ **Gender:** M F

Name: _____ **Parent/Spouse:** _____

Mailing Address: _____**City/State/Zip**: _____

Home Phone: _____ **Work Phone**: _____**Cell:**_____

Marital Status: □ **Single** □ **Married** □ **Widowed**

Employer/School Name: _____

Please tell us who referred you to us so we can thank them? (if no referral, how did you find us?)
_____

Nickname (If applicable): _____

E-mail address (required): _____ (used for appt verification if necessary)

□ **Cash** □ **Insurance** □ **Credit Card: Visa, MasterCard, Discover (Amex is not accepted**)

Insurance Information

Insurance Co: □ **BC/BS** □**Humana** □ **United Healthcare** □ **other** _____

Subscriber Id# _____ **Plan/Group #** _____ **SSN:** _____

Main Subscriber's Name: _____ **DOB:** _____

Mailing Address: _____ **City/State/Zip**: _____

Subscribers' Employer _____

Authorization # (if required) _____ **# of visits allowed (12 or 24 mon.)** _____

Primary Care Physician: _____ **Practice Group Name:** _____

Address: _____**Zip** _____**Phone:** _____**Fax:**_____

Co-Pay: _____ **Deductible:** _____ **Deductible Met:** _____

***(This information in not a guarantee of coverage, we will not know your exact benefits & coverage until we receive an explanation of benefits from you insurance company after first billing)**

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Patient Notification of Privacy Policies

Purpose: to document the disclosure of policies regarding the storage, use and sharing of confidential information. In addition to the general information provided, patients may request to review the Leaps in Language Privacy Policy Procedure Manual.

1. Confidential information is stored in a secure location away from public access.
2. Anyone who has access to any confidential information must sign a confidentiality agreement.
3. Employees are given a copy of the Privacy Policy Procedure Manual.
4. Employees have access only to information required to complete their job responsibilities.
5. Evaluations, therapy plans, progress reports and treatment notes are sent to Insurance companies, other pay sources, and referring physicians for the purposes of requesting doctor's orders, authorization for services, or to obtain reimbursement for services. Information may be sent via first class mail or fax with procedures in place to limit the likelihood of unauthorized access. This information will be sent one time and the date sent will be documented. If an additional request for the same information is made, the patient/guardian will be given the documents for submission.
6. Confidential Information is not shared with 3rd parties (with the exception of those listed above) without written approval from the patient or guardian.
7. Any organizations requiring access to confidential information from the clinic have signed a "Chain of Trust Agreement" promising to follow procedures to guard confidentiality.
8. Therapists share information with each other and referral sources only as needed to provide the best services possible.
9. Giving photographs to the clinic is considered authorization for displaying the pictures in the waiting room.
10. Parents can observe therapy in the therapy room or through the viewing window if available.
11. The Office Manager serves as the Privacy Officer. If any client/guardian has concerns that confidentiality has been or is in danger of being breached, they are asked to report it to the Privacy Officer.
12. All attempts should be made to hold conversations, which may include confidential information in a location away from public access.
13. All computers containing confidential information are only accessed via a password. Employees only have access to information critical for their job responsibilities.
14. By requesting or initialing e-mail communications, patients/guardians agree to release Leaps in Language and its employees for any breach of confidentiality that may occur with information transmitted over the internet. Leaps in Language will not share information with 3rd parties or referral sources over the internet.

I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES PRESENTED IN THIS DOCUMENT.

Signed (ResponsibleParty):_____**Date:**_____

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Financial Policies

1. **INSURANCE:** The information provided is not a guarantee of coverage; we will not know your exact benefits and coverage until we receive an explanation of benefits from your insurance company after the first billing. We will file your insurance claim for you based on the information you supply to us. We will handle all appeals to the best of our ability, but you agree to be financially responsible for all charges. You will receive a statement every month your account shows a balance due, regardless of insurance expectations. If at the end of ninety (90) days, your insurance has not paid, you will be responsible for the entire balance. If payment is received from your insurance company after 90 days, you will receive a credit on your account. Please inform us of any changes in your address, phone numbers, employment and medical benefits. Patients can seek assistance for self filing with your insurance company if Leaps in Language is not currently a provider for your plan. Please inquire about this if you need additional information.
2. **SELF-PAY PATIENT**S: Payment is due at the time of service. If your child is seen offsite, payment must be given to the therapist at each visit. For convenience, we also have the option of auto-charging your visits. We can obtain your credit card information from you and charge your credit card at the time of each visit. Please contact our office if you wish to use this service.
3. **APPOINTMENT POLICY:** Attendance is crucial for progress. **Please notify the office 24 hour in advance regarding cancellations or rescheduling.** One failure to cancel will be allowed per year to account for emergencies. However, after that the **FULL** payment for the session will be owed for any missed session. Considerations will be made in the event of emergency.
4. **CONFIDENTIALITY:** In an effort to ensure confidentiality we are unable to speak with anyone other than the patient or responsible party regarding an account without written approval from the patient.
5. **ASSIGNMENT OF BENEFITS:** I hereby assign all ancillary benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Leaps in Language rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.
6. **AURTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Leaps in Language, and any Therapists associated with Leaps in Language to: (1) release any information necessary to insurance carriers regarding my diagnosis & treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested Speech & Language services from Leaps in Language on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. **I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. We accept Cash, Check, Visa, MasterCard, or Discover as valid payments**

I HAVE READ, UNDERSTAND AND AGREE TO THE STATEMENT OUTLINED ABOVE.

Signed (ResponsibleParty):_____**Date:**_____

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Clinic Policies

1. **OBSERVATIONS**
   a. Student/Interns - Leaps in Language works closely with area Universities to assist in the training of new Speech/Language Pathologists. We often have students observe therapy sessions to learn more about what we do. These students sign confidentiality agreements and will not disturb the therapy sessions. In addition, we occasionally accept graduate student interns who will participate in therapy sessions under 100% direct supervision.
2. **SESSIONS**
   b. **HOLIDAYS**- Attached you will find a schedule of holidays during which the clinic will be closed. All sessions scheduled for these days will be rescheduled unless prior arrangements have been made with the therapist.
   c. **PUNCTUALITY**- To provide an excellent progress it is important to ensure that all scheduled appointments are seen promptly. In the event that you arrive late to your session, your time will still end at the appointed time.
   d. **ATTENDANCE**- This is crucial for progress and scheduling. Please notify the office 24 hours in advance regarding cancellations and rescheduling. (See financial policy for details). After 3 cancellations or failure to attend the client's session attendance will be considered inconsistent. This will forfeit having a standing appointment and the client will have to schedule appointments weekly.
3. **PARKING**
   a. Please park in the spaces labeled Leaps in Language. There are two spaces near the door and one additional space located near the fence.
   b. If Leaps in Language's spaces are occupied please use the unmarked spaces located facing NASA Parkway
4. **PAYMENTS**
   a. Full payments must be rendered at the time of service. Payments may be put in the black lock box on the wall in the waiting room.
   b. Please make checks payable to: Leaps in Language
   c. You will receive an invoice the following month of payment unless specify you would like weekly. A receipt can be provided at the time of payment if requested.
5. **QUESTIONS AND CONCERNS**
   a. If you any difficulties with your therapist treatment techniques being used or anything else that relates directly to the therapeutic process, please express your concerns directly to the therapist. If you are unhappy with the outcome or your discussion, please call Melissa Hernandez at the office to discuss your concerns. We are always willing to assist in any way possible.
   b. If you have any questions or concerns about billing or scheduling please contact our Executive Administrator, Patricia Bedel.

I HAVE READ, UNDERSTAND AND AGREE TO THE STATEMENT OUTLINED ABOVE.

Signed (ResponsibleParty):_____**Date:**_____

Observed Holidays 2009

In the event that the holiday falls on a Saturday, the office will be closed on the previous Friday. If the holiday falls on a Sunday, the office will be closed on the following Monday.

Good Friday

Easter Monday

Memorial Day

4th of July

Labor Day

Thanksgiving Day

Friday after Thanksgiving

Christmas Eve Observed

Christmas Day Observed

New Years Eve Observed

New Years Day Observed

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Insurance Verification Form

This is a reference form for your use only

We recommend that you ask specific questions when contacting your insurance company and keep careful records of all conversations including names of people you have spoken to, the information given to you and the dates you made contact. Please be advised that regardless of information given over the phone, most insurance companies will not guarantee payment. Historically, most insurance companies will only cover speech/language therapy if there is a medical condition present and the therapy is restorative in nature. Your speech/language pathologist and physician should be consulted to determine if a medical condition is present.

Name of Contact: _____ Date Called: _____

Questions to Ask:

1. Is speech therapy covered under my insurance plan? If so what specific condition(s) is speech therapy covered for (diagnosis)?
2. Is LEAPS IN LANGUAGE a participating provider with my insurance company?
3. If no does my policy allow services to be provided by an "Out of Network" provider and how much will I be responsible for?
4. Are there any limitations regarding age of the patient or the types of disorders covered?
5. What is the maximum number of therapy sessions allowed per calendar year?
6. If my child requires more than the maximum number of visits allowed per year, what is the procedure to get further visits approved and paid?
7. Do I have a "co-pay" or "percentage" per session? How much?
8. What is the deductible amount that I must pay before my insurance will begin reimbursing me?
9. Is this deductible amount based on the actual cost of therapy or the percentage the insurance company will pay?
10. Are my "co-pays" applied to the deductible?
11. What percentage of the fee will be paid?
12. Is it necessary to obtain prior approval for speech therapy? If so, what specific paperwork is required?
13. Is it necessary to obtain prior approval for speech therapy? If so, what specific paperwork is required?
14. Is it necessary to obtain a "letter of medical necessity: from my primary care provider and/or speech/language pathologists
15. Will my speech/language pathologist be required to send progress reports and treatment plans? If so how often will these need to be sent?
16. How long can I expect to wait for reimbursement after I submit an invoice?
17. What is the procedure for filing a grievance if therapy is not covered?

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Consent for Release of Information

I, _____ **authorize** the release of information including educational, evaluation, and therapy documentation, as well as verbal communication regarding my child:

_____ _____
Child's Full Name **Date of Birth**

FROM:	TO:
Leaps in Language 18096 Kings Row, Suite G Houston, TX 77058 Phone: 281-957-9070 Fax: 281-957-9102	_____ Practice Name Provider Name _____ Address _____ City State Zip Code (____)_____(____)_____ Phone Number Fax Number

FROM:	TO:
_____ Practice Name Provider Name _____ Address _____ City State Zip Code (____)_____(____)_____ Phone Number Fax Number	Leaps in Language 18096 Kings Row, Suite G Houston, TX 77058 Phone: 281-957-9070 Fax: 281-957-9102

This information is to be used for diagnostic and treatment planning purposes only. Thank you for your prompt attention in this matter.

_____
Parent/Guardian Signature

_____
Date of Request

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Physician Order Form

Please approve our request to evaluate and/or provide treatment for your patient by signing below. Formal and informal testing will be administered to determine the appropriate treatment plan for:

Speech/Language Therapy _____

Patient Name: _____

Date of Birth: _____

Diagnosis:_____

Physician's Name:_____

Physician's Signature: _____ Date: _____

Physician's Practice Name: _____

NPI Number: _____

UPIN Number: _____

Media Release

On occasion, therapy sessions may be videotaped. These tapes are used by the therapists to improve their treatment skills, document progress and for therapeutic purposes within the client's individual or group therapy. On occasion, these videos are used for training other therapists and identifying information is kept to a minimum. Please sign at the appropriate place below indicating your authorization for use of videotaped sessions for training purposes.

1. **I AUTHORIZE THE USE OF VIDEO TAPES FOR THE PURPOSES OF TRAINING.**

Signed (ResponsibleParty):_____**Date:**_____

2. **I <u>DO NOT</u> AUTHORIZE THE USE OF VIDEO TAPES FOR THE PURPOSES OF TRAINING.**

Signed (ResponsibleParty):_____**Date:**_____

Publication/Photos/Other Media

Leaps in Language has my permission to use photographs, anonymous work samples, quotations, etc. from my child in the use of publications, advertising, and staff or University Student training. I understand that appearances by my child in any such media publications will be made voluntarily and without compensation of any kind.

1. **I hereby GIVE my permission for my child to participate in media events which may occur without prior notice.**

Signed (ResponsibleParty):_____**Date:**_____

2. **I hereby DO NOT GIVE my permission for my child to participate in media events which may occur without prior notice.**

Signed (ResponsibleParty):_____**Date:**_____