Let's Talk Speech and Language Therapy, Ltd.
INITIAL FORM - PATIENT & INSURANCE DATA

Please complete each page (front & back) in packet

Please return PRIOR to your child's first appointment

CONTACT INFORMATION	
Child's Name:	Date of Birth:
Parents/Guardian:	Child's Chronological Age:
Parents/Guardian:	Home Telephone:
Address:	Cell Phone:
City, ST, Zip:	E-mail Address:
Ethnicity:	Referred by:

MEDICAL INFORMATION
Physician's Name:
Practice:
Allergies/Special Health Considerations:

INSURANCE INFORMATION

Our office manager will use this form to submit claims electronically. We are currently in-network for Anthem Blue Cross PPO, Blue Shield PPO, United Healthcare PPO, CIGNA PPO, Kaiser, and Monarch HMO.

Name of Insurance Company:
Identification Number:
Identification Number for child (if different):
Group Number:
Name on Insurance Card:
Primary Card Holder's Name as it appears on card:
Primary Card Holder's Date of Birth:
Are codes 92523 & 92507(treatment) covered?:
Are there any limitations to coverage, such as having to be a "medical condition"?:
Is a Preauthorization required?:
Yearly Deductible (family/child):
Deductible met so far (family/child):
Co-pay / Co-insurance amount per session:
Speech & Language treatment sessions allowed per year:

Let's Talk Speech Therapy
Helping Kids Blossom

CASE HISTORY FORM

Family Information

Child's Name:	Child's Date of Birth:
Male or Female:	Child's Chronological Age:
Mother's Name:	Residing City:
Mother's Occupation:	Referred by:
Father's Name:	Pediatrician:
Father's Occupation:	Health Insurance:

Child lives with (check one):

❑ Birth Parents ❑ Adoptive Parents ❑ Foster Parents ❑ Parent and Step-Parent ❑ One Parent ❑ Other

Other children in the family:

Name:	**Age:**	**Speech & Language Delay (if yes, please describe)**
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

Family Members - Other delays (please check):

- ❑ Autism / Family Member
- ❑ Receptive-Expressive Language Delay / Family Member
- ❑ Speech (articulation delay)
- ❑ ADHD / Family Member
- ❑ Behavioral Challenges / Family Member
- ❑ Other / Family Member
- ❑ Stuttering

Is there a language other than English spoken in the home? ❑Yes ❑No. **Name of Language**:_____

Does the child speak the language? ❑ Yes ❑ No Does the child understand the language? ❑ Yes ❑ No

Who speaks the language?

PREGNANCY & DELIVERY

Was there anything unusual about the pregnancy or birth? ❑ Yes ❑ No If yes, please describe.

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? ❑ Yes ❑ No If yes, please describe.

How many months was the pregnancy? _____

Did the child go home with his/her mother from the hospital? ❑ Yes ❑ No

If child stayed at the hospital, please describe why and how long.

DEVELOPMENTAL MILESTONES

Please tell the approximate age your child achieved the following developmental milestones:

SKILL	AGE ACQUIRED
Sat Alone	
Walked	
Babbled	
Said first words	
Put two words together	
Spoke in sentences	
Toilet trained	

Please describe your speech and language concerns:

_____

_____

_____

Please describe any behavioral concerns you may have:

_____

PREVIOUS EVALUATIONS

Has he/she ever had a speech and/or language evaluation/screening? ❑ Yes ❑ No

Where & When?

_____

Diagnosis:

Did he/she have a Newborn <u>hearing</u> screening? ❑ Yes ❑ No **Results:** ❑ Passed ❑ Did Not Pass

Has he/she ever had a <u>hearing</u> evaluation/screening? ❑ Yes ❑ No

Where & When?

_____

Results:

Has your child ever had <u>speech therapy</u>? ❑ Yes ❑ No

Where & When?

_____

Diagnosis:

Has your child received any other evaluations or therapy (PT, OT, ABA, etc.)? ❑ Yes ❑ No

Where & When?

_____

Diagnosis:

<u>MEDICAL / OTHER</u>

Is your child aware of, or frustrated by, any speech/language difficulties? ❑ Yes ❑ No

Has your child had any of the following?

❑ adenoidectomy	❑ encephalitis	❑ seizures
❑ allergies	❑ flu	❑ sinusitis
❑ breathing difficulties	❑ head injury	❑ sleeping difficulties
❑ chicken pox	❑ high fevers	❑ thumb/finger sucking habit
❑ colds	❑ measles	❑ tonsillectomy
❑ ear infections #_____	❑ meningitis	❑ tonsillitis
❑ ear tubes	❑ scarlet fever	❑ vision problems

Please list any medications your child takes regularly:_____

Does your child...

- ❑ choke on food or liquids?
- ❑ currently put toys/objects in his/her mouth?
- ❑ drool frequently?
- ❑ brush his/her teeth and/or allow brushing?

Does your child...

- ❑ repeat sounds, words or phrases when asked?
- ❑ retrieve/point to common objects upon request (ball, cup, shoe)?
- ❑ follow simple familiar directions ("Shut the door" or "Get your shoes")?
- ❑ respond correctly to yes/no questions?
- ❑ respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

- ❑ body language.
- ❑ sounds (vowels, grunting).
- ❑ words (shoe, doggy, up) – approximately how many: _____
- ❑ 2 to 4 word sentences.
- ❑ sentences longer than four words.

Behavioral Characteristics:

- ❑ cooperative
- ❑ attentive
- ❑ willing to try new activities
- ❑ plays alone for reasonable length of time
- ❑ separation difficulties
- ❑ easily frustrated/impulsive
- ❑ stubborn
- ❑ restless
- ❑ poor eye contact
- ❑ easily distracted/short attention
- ❑ destructive/aggressive
- ❑ withdrawn
- ❑ self-abusive behavior
- ❑ picky eater (limited textures)
- ❑ good sleeper
- ❑ walks on toes often
- ❑ fearless
- ❑ sucks his/her thumb
- ❑ uses pacifier
- ❑ falls frequently / unaware of surroundings
- ❑ flaps hands when excited or other times
- ❑ looks at toys in a horizontal position on the floor
- ❑ sensitive to loud noises
- ❑ tantrums longer than 30 minutes each day
- ❑ has difficulty transitioning from one activity to another

If your child is in school, please answer the following:

Name of school and grade in school: _____

Days/Times attends school:_____

Does your child have an IEP? ❑ Yes ❑ No

If yes, what services is your child currently receiving? (please provide us a copy of his/her IEP)_____

_____

_____

Check / List preferred play activities:

❑ Cars, trains, planes, etc.
❑ Cause-Effect play
❑ Bubbles, wind-up toys, shape sorters, etc.
❑ Farm animals
❑ Pretend Kitchen play
❑ Coloring / Fine motor activities
❑ Going to the park, swinging, sliding, climbing, etc. (gross motor activities)
❑ My child really likes the characters (i.e., Mickey, Cars, Princesses, etc.) : _____
❑ Other: _____

Additional Information you would like to share:

_____

_____

_____

_____

_____

_____

WELCOME – Policies and Procedures

PLEASE INITIAL NEXT TO EACH ITEM AND SIGN AT THE BOTTOM (3 PAGES)

_____ THERAPY SESSIONS

- **Direct therapy sessions are 25 to 27 minutes.** The last 3 to 5 minutes may be used for consultative services and/or documentation purposes.
- **THERAPISTS** - Let's Talk Speech will do our best to maintain your child's consistent schedule with the same scheduled therapists. However, please note that your child's therapist may change without notice due to unforeseen circumstances and/or the needs of the business occasionally.
- **If you choose to leave the therapy session, please be prompt in picking up your child.** When his/her session is over we do not have means for childcare. Please be available for your consultative time to discuss your child's progress (i.e., 8:25, 8:55, etc.).

_____ PAYMENTS / INSURANCE

- **INSURANCE.** Clients are responsible for determining their insurance benefits. As a courtesy, our office manager can assist you with your benefits. The office manager will need the completed Initial Patient Data form and a copy of your insurance card.
- **VISIT MAXIMUM-**Once it has been determined how many visits are covered by your insurance per calendar year the office manager will notify you via email and it is then **your responsibility** to keep track of how many visits your child has used. We will submit claims for you as a courtesy.
- **PAYMENTS – Payments will be collected at each appointment.**
- **Claims will be electronically submitted to your insurance company daily.** Claims take approximately 4 to 6 weeks to process**.** If payment is not issued by your insurance plan within 60 days of initial filing, you are responsible for payment in FULL for all services rendered. It is then your responsibility to follow up with your insurance company regarding reimbursement.
- Please understand that if your insurance company delays payment or is waiting on additional information/medical records before they render payment, and the balance is past due 60 days**, the balance is your responsibility and is due immediately.**
- We accept checks, **MasterCard** and **Visa**
- We are currently **in-network providers** for Blue Shield of California PPO, United Health Care PPO, Anthem Blue Cross PPO, Cigna PPO, Kaiser, and Monarch HMO
- ***You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co- insurance amounts or any other patient responsibility indicated by your insurance carrier or our FINANCIAL POLICIES, which are not otherwise covered by supplemental insurance.***
- ***You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.***

____ REGIONAL CENTER OF ORANGE COUNTY (RCOC) CONTRACTS

- Therapy fees will be submitted to the RCOC.
- The RCOC requires that each client to continue to appeal their insurance denial for speech and language therapy services. Please consult with your RCOC Service Coordinator if you have questions regarding this matter.
- The RCOC will not pay for past visits if a contract is not in place. If the RCOC contract ends and you begin using your insurance, the RCOC will not pay for any services not covered by your insurance plan. You will then need to contact the RCOC and ask for a new contract to be put in place.
- Once you have exhausted your insurance, RCOC may fund for additional ongoing therapy **IF** your child continues to qualify under their qualification guidelines.

_____ ATTENDANCE / FEES APPLIED to NO-SHOWS and less than 24 HOUR cancellations

- **CANCELLATIONS –** We understand everyone has very busy schedules. However, please give us a minimum of a 24 hour cancellation notice. This helps us in scheduling new evaluations and make-up sessions for other children. Please refer to our Cancellation Policy for details.
- **A "no-show"** fee of $40.00 will be applied to your invoice when a "no-show" occurs. This also applies to RCOC contracts and you will receive an invoice.
- **Scheduled vacations or extended absences** that require a child to miss 2 or more weeks in a row of regularly scheduled appointments may result in losing your child's regularly scheduled treatment day/time. If this occurs and you would like to bring your child back, we will do our best to resume your child's previous treatment schedule.
- **If RCOC** clients want to make up any missed therapy sessions, RCOC states sessions may be made up it must be made up within the month of the missed appointment. Please refer to the POS contract. If you know you are not going to attend a Thursday or Friday session, please let us know in advance and we can try to schedule your session earlier in the week.
- You will be notified as far in advance as possible when your clinician is ill, on vacation or attending a continuing education conference. Every effort will be made to have another clinician cover the session and/or reschedule your appointment so that your child can attend his/her session.
- If you need to make changes to your child's therapy schedule please e-mail Jill at letstalkspeech@cox.net. Thank you.

_____ HEALTH & WELL BEING

- **Please do not bring your child if he/she has a fever or has vomited within the last 24 hours.** Children do not perform well under these conditions and expose other children to illness.

_____ REPORTS

- **A review of your child's progress will be conducted approximately every six months or yearly depending on your child's age and needs.** At that time, we will provide you with a written report.

_____ THERAPISTS

We will do our best to maintain consistency with your child's regularly scheduled therapist. However, please note that there may be temporary therapist changes without prior notice due to a variety of reasons. Thank you for understanding.

_____ PHONE CALLS / OTHER / EMAIL

- Please do not hesitate to contact us if you have any questions or concerns.

Signature Parent/Guardian _____

CANCELATION POLICY

Please read, sign and return

Dear Parents,

Cancelations, especially last-minute cancels, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. We must ask for your full cooperation with the following cancelation policy.

NO-SHOW / LATE CANCELATION FEES

- ALL no-show appointments will be charged a $40.00 no-show fee.
- ALL late-canceled appointments will be charged a $40.00 late cancelation fee.
    - Appointments must be cancelled by 4:00 p.m. the day PRIOR to your scheduled appointment. If you need to cancel a Monday appointment, please contact the office before 4:00 p.m. on Friday.
    - Appointments canceled one hour before the session will be charged a $40.00 late-cancelation fee.
    - Please note, we do not listen to voicemail messages on the weekends.
- If your child should be ill the morning of his/her scheduled appointment, please notify the office right away. We will allow this appointment to be rescheduled for a later date without a cancellation charge.

TO CANCEL AN APPOINTMENT

- Email letstalkofficemanager@gmail.com
- Call (949)218-0508
- Text (949)264-5236

EXPLANATION of CANCELATION POLICY

- Consistent therapy is key to progress.
- Let's Talk Speech provides an Email Reminder the day before your appointment and a Text Reminder an hour before your child's session.
- There are children on the wait list for popular days/times. No-show and late cancelations do not allow our team to offer that spot to another child.
- We staff according to the needs of our clients. A no-show and/or late cancelation adversely affects our therapists' schedules.

I have read and understand the above cancelation policy for Let's Talk Speech and Language Therapy.

Name of patient (please print)_____

_____

Signature of responsible person_____ Date:_____

_____

FINANCIAL RESPONSIBILITY & INSURANCE

YOUR INSURANCE PLAN

It is your responsibility to know the following:

Ask you Insurance Company the following:	
Is speech and language therapy covered? *Treatment code 92507 and evaluation code 92523* Common diagnosis codes: • *F80.0 Phonological / Articulation Disorder* • *F80.1 Expressive Language Disorder* • *F80.2 Receptive Language Disorder* • *F80.81 Fluency Disorder* • *F84.0 Autism Spectrum Disorder*	
Is this a calendar year plan? How many **visits** of speech therapy are allowed per calendar year?	
Are speech and language therapy visits combined with other therapies, such as occupational therapy and physical therapy?	
Does my plan have a **deductible**? Is speech therapy subject to the deductible? If so, how much of the deductible has been met to date? When will my deductible start over?	
Does my plan have a **co-payment or co-insurance** amount? How much is the co-pay and/or co-insurance amount (i.e., 20%/80%, 30%/70%, etc.) per session?	

Does my plan require a **prescription** for speech therapy from my child's pediatrician? Does my plan have any exclusions for speech therapy?	

ADDITIONAL INSURANCE DATA	**Please Initial indicating your understanding**
Insurance companies may state speech and language therapy is a covered benefit. However, please note, it is not a guarantee of payment/coverage and services may be denied. If this occurs, you may file an appeal with your insurance company. Your insurance company can assist you with the appeals process.	
If your insurance plan does not cover therapy and/or denies claims at any time, you are financially responsible for all past services rendered immediately. If you choose to continue, you may continue as a private pay client.	
If your insurance plan denies coverage, Let's Talk Speech will make up to ONE attempt to submit your child's claims to your insurance company. After the initial attempt, you will be billed for the full amount of services provided and you will be financially responsible for that amount. With this said, you can continue to follow up with your insurance company to obtain reimbursement.	
Treatment visits in your plan does not guarantee insurance coverage and/or reimbursement, as some insurance plans have exclusions.	
Different insurance plans within each insurance company have different exclusions and limitations.	

You are responsible for any deductibles, co-payments and/or coinsurance fees at the time of service.	
It is your responsibility to notify Let's Talk Speech and Language Therapy, Ltd. of any insurance changes.	

HIPAA Notice of Privacy Practices

Let's Talk Speech and Language Therapy
777 Corporate Dr. #230
Ladera Ranch, CA 92694
(949) 218-0508

**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable 1Du Health Oversight: Abuse or Neglect: Food and Drug Administration requirements:

This notice was published and becomes effective on or before **August 14, 2002**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

HIPAA Notice of Privacy Practices