Welcome to Beyond Speech Therapy!

We are excited to work with you and your family. Thank you for choosing Beyond Speech Therapy. It is our desire to create a positive experience in every aspect of your journey with us. We are committed to providing the highest quality, comprehensive, and evidence-based services. Please let us know if you have any concerns or questions. Beyond Speech Therapy is here to support you.

The attached *New Client Forms* include **Client Intake Packet, Client Privacy/HIPPA, Insurance/Payment, Credit Card on File Policy, Practice Policies, Check in Procedures and a Guide to Understanding Insurance**. Please fill out these forms completely. If you have had any recent evaluations completed by other health professionals (Psychologist, ENT, Oncologist, Neurologist, Gastroenterologist etc.), please also complete the ***Authorization to Release Form***. While we understand these forms are extensive, the information is important in the assessment and plan of care processes.

We will contact you and provide an estimate of costs before your evaluation. Please remember to arrive at least 15 min before your scheduled appointment with your completed paperwork to allow for check-in procedures. If you need to complete your paperwork in the office and/or require assistance, please arrive at least 30 min before the scheduled appointment time and our staff will gladly assist you. Thank you, and we look forward to meeting you.

Contact Information:

For more information about Beyond Speech Therapy and services provided, please visit www.beyondspeechtherapy.net

Location Address: 6965 San Luis Ave, Atascadero, CA 93422

Phone: 805.591.7188 Fax: 805.591.7189

Sincerely,

April Nolan M.Ed., CCC-SLP
Speech Language Pathologist
CEO, Beyond Speech Therapy, Inc

Candace Montgomery
Office Manager
info@beyondspeechtherapy.net

Beyond Speech Therapy

PATIENT INFORMATION

*******Please provide information as it is printed on the Patient's Insurance Cards******

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ DOB: _____

Address: _____ City: _____ State____

Zip Code: _____ Email: _____

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

PRIMARY CONTACT FOR SCHEDULING AND BILLING-

First Name: _____ Last Name: _____

If NOT the patient, relationship to patient: _____

Phone #1: _____ Ok to leave message: Yes _____ No _____

Phone #2: _____ Ok to leave message: Yes _____ No _____

Email _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

INSURANCE/PAYMENT INFORMATION- (Cards MUST be provided to copy)

Primary Insurance-

Subscriber Name: _____ DOB: _____ SS#_____

Primary Insurance Carrier: _____ Phone Number: _____

ID #: _____ Group #: _____Effective Date: _____

Secondary Insurance-

Subscriber Name: _____ DOB: _____ SS#_____

Primary Insurance Carrier: _____ Phone Number: _____

ID #: _____ Group #: _____ Effective Date: _____

_____ As a courtesy, BST will verify your insurance benefits. Verification is NOT a guarantee of payment. We suggest you contact your insurance provider to better understand your benefits.

_____ If insurance does NOT pay for services, BST will provide the patient/guarantor the necessary documentation to appeal for reprocessing of claims. Payment is ultimately the responsibility of the patient/guarantor.

Assignment of Insurance Payment Benefits:

I authorize the release of any payment and medical information necessary to process myself or my family member's insurance claim and related claims. I hereby authorize payment directly to Beyond Speech Therapy of the insurance benefits otherwise payable to me for all professional services.

Signature of Policy Holder/ Guarantor _____ Date: _____

PARTY RESPONSIBLE FOR PAYMENT

Name:_____ DOB: _____ SSN: _____

Address _____ Phone: _____

Employer Name: _____ Phone: _____

_____I have read and understand the payment policy and agree to pay for services rendered.

CONSENT FOR TREATMENT

_____ I hereby attest that I consent to evaluation and treatment or give my consent for the person under my legal guardianship, to receive services at Beyond Speech Therapy. I understand that I may terminate these services at any time by verbal or written notice.

PHOTOCOPY AUTHORIZATION

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Patient (Printed): _____ Date: _____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Patient/Guarantor Signature:_____ Date:_____

Chief Complaints/Symptoms-

☐ **Swallowing**	☐ **Anxiety**	☐ **Cognition**	☐ **Speech**
☐ **Voice**	☐ **Pragmatics**	☐ **Language**	☐ **Auditory Processing**

Anything else not listed above: _____

When did symptoms begin? _____ Describe symptoms:_____

_____

Beyond Speech Therapy

Have there been any significant changes in last six months? _____ If so, what? _____

_____

_____

Patient Medical History-

Please check all that apply (past or present):

___Seizures	**___COPD**	**___Asthma**	**___Dementia**
___High Fevers	**___Encephalitis**	**___Enlarged Glands**	**___Aspiration Pneumonia**
___Pneumonia	**___Rheumatic Fever**	**___Head/Neck Cancer**	**___Parkinson's**
___Tonsillitis	**___Tuberculosis**	**___GERD/Reflux**	**___Weight Loss(20lbs+)**
___Meningitis	**___ Sinusitis**	**___Vocal Cord**	**___Loss of Appetite**
___CHF	**___Chronic Colds**	**Paralysis**	

____Yes ____NO— Current Immunizations? (Not including COVID vaccine)

____Yes ____NO—Any Surgeries? If yes, please list: _____

____Yes ____NO—Any head or neck injuries or loss of consciousness? If yes, how many? _____

____Yes ____NO—Vision Problems? If yes, please explain: _____

____Yes ____NO—Do you wear glasses and or contacts?

____Yes ____NO—Hearing loss? If yes, do you wear hearing aids? ____Yes ____ No

____Yes ____NO—Missing any teeth? If yes, do you wear partials or dentures? _____

____Yes ____NO--Do you wear your dentures when eating?

Family Medical History-

Does anyone in your immediate family have a history of any of the following:

___Parkinson's Disease	**___High Blood Pressure**	**___COPD**
___ Dementia	**___Stroke**	**___Swallowing Disorders**
___ Cancer	**___ CHF**	**___ Seizures**

If yes, please specify type of Cancer: _____

Any other serious or recurrent illnesses? Yes_____ No_____ If yes, please list _____

_____

Medications-

Please list here or provide a printed copy of medications/vitamins/supplements and dosages:

_____Please initial here if providing a printed list or copy of medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Previous Speech Therapy evaluations/treatment? Please list estimated dates and therapist: _____

_____

Are you currently receiving home health therapy? ____Yes ____No If yes, which agency are you receiving services from? _____ When do you anticipate discharge? _____

Have you received *ANY* home health services this year including nursing and/or therapy? Yes_____ No_____

If yes, with which agency? _____ When were you discharged? _____

Please note

**Medicare will NOT pay for Home Health Services and Outpatient Services at the same time. The patient MUST be discharged from Home Health Services and the discharge reported to Medicare before Medicare will pay for Outpatient Services. If you have recently received, Home Health services, please contact the Home Health Agency and confirm the discharge date. **

**If you are receiving BOTH Home Health Services and Outpatient Therapy Services, YOU WILL BE RESPONSIBLE FOR FULL PAYMENT OF OUTPATIENT SERVICES RECEIVED AT BEYOND SPEECH THERAPY. **

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POLICIES AND PROCEDURES

CANCELATION POLICY

If you must cancel an appointment, please call immediately. Except under emergency circumstances and acute illness, all appointments cancelled with less than 24 hours of notice, will be subject to a service fee of $65.00 for therapy/evaluation sessions and $85 for Modified Barium Swallow Studies. There will be ONE "failure to cancel/NO show" courtesy provided. Insurance will NOT pay for NO SHOW/CANCELLATION fees.

LATE ARRIVAL POLICY

Patients arriving more than 10 min late, will not be seen and will incur a no show/cancellation fee of $65.00. Insurance will NOT pay for No show/cancellation fees. This fee must be paid before the next scheduled appointment.

CONFIDENTIALLITY

Your privacy is very important. Beyond Speech Therapy will only contact you via means that you have specifically authorized. If you would like Beyond Speech Therapy to exchange information with persons other than yourself, an Authorization for Release of Information form must be completed. All HIPPA guidelines will be adhered to at Beyond Speech Therapy.

PAYMENT

The patient/guarantor is responsible for payment at the time services are rendered unless other arrangements have been made in advance and in writing. Accounts more than 45 days overdue will be subject to a $20 late fee and 5% interest charge. Accounts more than 90 days overdue will be sent to collections.

IN-NETWORK INSURANCE BILLING/PAYMENT

For clients seeking third-party reimbursement, please be advised, you are ultimately responsible for the payment of services rendered. If your insurance carrier denies payment (including recoupment) or does not remit payment within 45 days, the client will be responsible for payment of all services rendered. It is recommended that you contact your insurance company to discuss the benefits and limits of your policy.

OUT OF NETWORK INSURANCE BILLING/PAYMENT

If Beyond Speech Therapy is out of network with your insurance, we will bill your insurance to assist you in seeking reimbursement for out-of-network provider services. Please also be advised that many health insurance plans have limited coverage for speech-language pathology services. It is recommended that you contact your insurance company to discuss the benefits and limits of your policy.

TERMINATION/DISCHARGE OF SERVICES

- **Financial**

If you do not fulfill your financial obligations to Beyond Speech Therapy and remain delinquent on your account for more than 30 days without payment, services will be suspended until payment is received. Scheduled sessions will be cancelled and day/time slots will not be held.

- **Attendance**

Due to the importance of continuity of care, regular attendance to appointments is necessary. If excessive appointments are missed and/or canceled for ANY reason, Beyond Speech Therapy reserves the right to discharge services.

- **Compliance**

Beyond Speech Therapy reserves the right to discharge for but not limited to, not complying to policies, recommendations, attendance and financial obligations.

PARTICIPATION/OUTCOMES

Optimal outcomes are always our goal, however Beyond Speech Therapy does not guarantee results. Optimal outcomes require participation from both parties. It is imperative that patients follow their plan of care and recommendations from their therapist. Home exercise plans will be provided and must be completed as directed to reach goals as planned.

HEALTH AND WELLNESS POLICY

- If the client appears ill or febrile, the staff will obtain their temperature, and if a fever is present, the client will not be seen. The client must be temperature-free for 48 hours before returning to therapy. If you have been vomiting and/or diarrhea, please do not return to therapy until 48 hours have passed since the last episode of the same.
- If you are experiencing any respiratory symptoms, with or without a fever, please reschedule.
- **Please do not bring sick or febrile family members inside the clinic.**

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Authorization to Release Information

Name of Patient: _____

Date of Birth: _____ **Social Security #:** _____

I hereby authorize Beyond Speech Therapy to: **_____Obtain information from the following**

_____Release information to the following

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

The documents to be released are described or listed as:

- ☐ **Visit Notes**
- ☐ **Evaluations**
- ☐ **Tests**
- ☐ **X-rays/Scans**
- ☐ **MBSS**

I understand that my authorization will remain effective from the date of my signature until I provide in writing to end the authorization. The information will be handled confidentially in compliance with all applicable HIPPA and federal privacy laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written and dated communication.

I have read and understand the nature of this release.

Patient/Guarantor's Signature: _____ **Date:** _____

Witness: _____ **Date:** _____