6965 San Luis Ave
Ph. 805.591.7188
Fax 805.591.7189
beyondspeechtherapy.net

Welcome to Beyond Speech Therapy!

We are excited to work with you and your family. Thank you for choosing Beyond Speech Therapy. Most likely, you have had to wait for an extended period of time to be scheduled with us, and we appreciate your patience. Unfortunately, the needs of our community for Speech Pathology services are much larger than the number of providers in our area. Our clients are typically with us for a few months up to several years depending on their diagnosis and needs. Therefore, openings on the schedule typically occur once clients meet their goals and no longer require services. Scheduling availability is extremely limited. Once you are scheduled for your evaluation and follow up services, we will do our best to accommodate schedule change requests but cannot guarantee there will be additional openings to select from. 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.

Kindly,

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

Candace Montgomery
Office Manager
info@beyondspeechtherapy.net

PATIENT INFORMATION

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

First Name: _________________________________ Middle Initial: ______ Last Name: ___________________________

Preferred Name: _____________________________ Gender: __________________________DOB: _________________

Address: ___________________________________ City: ___________________________ State_____ Zip Code_________

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: _____________

CURRENT CHIEF COMPLAINTS/SYMPTOMS

Swallowing		Anxiety		Dysarthria		Cognition/Memory		Receptive Lang.	
Word Finding		Voice		Social Skills/Pragmatics		Auditory Processing		Aphasia	

Anything else not listed above: ____

When did the symptoms begin? _______________________________ Describe symptoms:_______________________________

____

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

____

PATIENT MEDICAL HISTORY

Please check all that apply (past or present):

COPD/ Asthma		High Blood Pressure		CHF		Seizures		High Fevers		Meningitis		Tonsilitis		Vocal Cord Polyps	
TB		Chronic Colds		GERD/ Reflux		Sinusitis		Encephalitis		Rheumatic Fever		COVID		Pneumonia	
Brain Injury		CVA/ STROKE		Loss of appetite		Weight Loss		Parkinson's		Dementia		Memory Loss		Aspiration Pneumonia	
Bell's Palsy		Anoxia		Falls		Concussion		Vocal Cord Paralysis		Diabetes Type I or II		Cancer- _______		Head/Neck Cancer	

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

____

____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:

Dysphagia		CHF		Dementia	Cancer		High Blood Pressure		Seizures	
Cancer Type- ____________		COPD		Parkinson's	CVA/Stroke		Voice Disorder		Dementia/Alzheimer's	

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? Please list estimated dates and Provider: _____________________________________

____

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? ________________________

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 reported to Medicare, not the date they discontinued services. **

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

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.

ASSIGNMENT OF INSURANCE 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: _________________

_____ CONSENT FOR TREATMENT

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

_____PAYMENT & FEES

- The person listed as the *Party Responsible for Payment* is responsible for payment of all services rendered. If insurance does not provide payment, that is between the responsible party and insurance. Co-pay/Co-insurance is due at the time services are rendered. Accounts more than 45 days overdue will be subject to a $20.00 late fee and 5% interest charge. Accounts more than 90 days overdue will be sent to collections. At that time, all payments and communication will go through collections.
- Fees apply to various types of services including direct client contact, phone consultations, IEP/504 meetings and consultations with other professionals.
- For clients seeking third-party reimbursement, please be aware that 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 of claims submission, the patient/guarantor will be responsible for payment of all services rendered.
- If your claims are denied, Beyond Speech Therapy will appeal one time for reprocessing. After the first appeal, if the claims are denied again and not paid, BST will provide the patient/guarantor with the necessary documentation to appeal for reprocessing of claims and reimbursement. The balance on the account will be due at that time. If a payment plan is needed, please speak to management. A formal written agreement will be completed by both parties.
- It is the patient/guarantor's responsibility to notify Beyond Speech Therapy of ANY changes to your insurance at the time those changes occur.

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, even if my insurance denies coverage and 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.

_____CANCELLATION 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 as indicated below:
    1. Evaluations- $150.00
    2. Modified Barium Swallow Studies- $150.00

3. Treatment Sessions- $115.00

______ **LATE ARRIVAL POLICY**

First Visit/Evaluation

- **Complete Paperwork**
  Clients must arrive 15 min prior to their scheduled appointment time to allow for check-in procedures. If you arrive at your scheduled time, it is possible that you may not be seen and will incur a "No Show/Cancellation Fee" of $150.00. This fee must be paid before the evaluation is re-scheduled.
- **Need to complete Paperwork**
  Clients must arrive 45 min prior to their scheduled appointment time to allow for check-in procedures. If you arrive less than 45 min prior to the scheduled evaluation, without completed paperwork, you risk not being seen and will incur a "No Show/Cancellation Fee" of $150.00. All intake paperwork MUST be completed and turned in at least 15 minutes prior to the evaluation, to allow the therapist time to review the chart and prepare accordingly.

Treatment Visits

- Clients must arrive "on time" to their scheduled appointment to allow for check-in procedures. If you arrive after the scheduled time, it is possible that you may not be seen. Clients who are more than 10 min late will not be seen and will incur a "No Show/Cancellation Fee."
- **No Show/Cancellation Fee**
  Insurance will NOT pay for No Show/Cancellation fees. This fee must be paid before the next scheduled appointment.

______**ATTENDANCE POLICY**

I understand that I will be moved to a "call-in/floater" status if more than (2) cancellation (1x week) or (3) cancellations for (2x week) are accrued over a 4-week period. If my child is removed from the schedule, it will be my responsibility to call the clinic daily to schedule my child if openings are available. (Illness/COVID exceptions)

_______**DROP OFF POLICY**

Clients who require caregivers or 1:1 care and exhibit cognitive-linguistic deficits with behaviors that pose a safety risk to themselves and others, must have an adult attend their appointments with them.

________**CONFIDENTIALLITY**

Your privacy is very important to us. It is recommended that you review the *Notice of Privacy Policy* for important details regarding policies for maintaining confidentiality. We will only contact you via means that you have specifically authorized in your new client paperwork. If you would like us to exchange information with people other than yourself, an *Authorization for Release of Information* form must be completed.

______**HEALTH INSURANCE**

We are "In-Network" with many insurance plans, but not all. If Beyond Speech Therapy is not contracted with your insurance, we will courtesy bill your insurance and/or provide you with a superbill 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. We recommend that you contact your insurance company to discuss your coverage.

______ **MEDICARE COVERAGE REGARDING HOME HEALTH SERVICES AND OUTPATIENT SERVICES**

I understand that Medicare will ***NOT*** provide benefits for Home Health and Outpatient services during the same episode. If it is determined that I am receiving home health services while attending services at Beyond Speech Therapy, I will be responsible for 100% of the costs billed to Medicare

_______**TERMINATION OF SERVICES**

- In the event, that you do not keep your financial obligations to Beyond Speech Therapy and remain delinquent on your account for more than 2 sessions, services will be suspended until payment is received, and the client will be removed from the schedule and loose desired days and times.
- If it is determined that continued participation will be a detriment to the client and/or their family, services will be terminated.
- Due to the importance of continuity of care, regular attendance to appointments is necessary. If excessive appointments are missed and/or canceled, Beyond Speech Therapy reserves the right to discharge services.
- The Speech Language Pathologist reserves the right and professional judgement to discontinue services at any time. Optimal outcomes are the goal, however not guaranteed.

- If at any time, the client and/or family member exhibits harmful, threatening, or inappropriate behavior, Beyond Speech Therapy staff reserves the right to discontinue services.

______HEALTH POLICY

- Help and cooperation is required to maintain a healthy environment. If a client appears sick, his/her temperature will be checked upon entering the office. If the client has a fever, he/she 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 the client and or any family members in the home experience any flu like or respiratory symptoms, all family members including the client must be symptom free for 2 days before the client can return to the office. Teletherapy services may be an option also.
- Children will not be seen if any of the following is present: Sick or too uncomfortable to function in the therapy setting, continual runny nose; thick or discolored nasal discharge; excessive sneezing or coughing and mucus-producing cough; elevated temperature.
- 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.
- Please notify us immediately if you or anyone in your family tests positive for COVID-19.

_______RECEIPT OF PRIVACY POLICY AND CONSENT FOR DISCLOSURE OF HEALTH INFORMATION & PATIENT'S RIGHTS

I have been provided a copy of Beyond Speech Therapy's Notice of Privacy Policies & Patient's Rights detailing how my medical record may be used and disclosed under Federal and State law. I understand that as a part of Beyond Speech Therapy's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Beyond Speech Therapy may refuse to treat me. I further understand that Beyond Speech Therapy reserves the right to change its privacy policies and will provide me with a copy of any revised notice.

PHOTOCOPY AUTHORIZATION

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

Name of Client (Print): ____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.

Client Signature____ Date: _____________

CONSENT TO AUDIO OR VIDEO RECORDING

I consent to allowing speech therapy sessions to be recorded via audio or video. I understand the purpose of this recording is to provide assessment points and tools of measurement. All audio and video files will be safely stored electronically in the client's file. I have been advised it will not be released for use in any public material or presentation and all HIPAA guidelines adhered to.

Client Signature ____Date: ______________

______ADDITIONAL SERVICES/RATES NOT COVERED BY INSURANCE

- $115.00 per 30 mins – Consultation (client not present)

Medical Records Requests

- $20 plus $.25 per printed page up to 50 pages
- $35 plus $0.25 per printed page for files between 50-100 pages

- $65 plus $0.25 per printed page for files between 100-200 pages
- TBD- All files over 200 pages
- Courtesy Copy of Evaluation(s) to be provided upon request
- Courtesy File sharing between all providers involved in patient's plan of care (By Fax Only- Paper Requests will incur charges