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

Beyond Speech Therapy

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.
april.nolan@beyondspeechtherapy.net

Candace Montgomery
Office Manager
info@beyondspeechtherapy.net

CLIENT INFORMATION

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

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

Preferred Name: _____ Gender: _____ DOB: _____

Address: _____City: _____ State: _____ Zip Code: _____

Primary language spoken in home: _____ Secondary language: _____

Pediatrician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Parents' Names: _____ Married ____ Divorced____

Child lives with: _____ Relationship to Child: _____

If divorced, what is the custody arrangement? Primary_____ Shared _____ If primary, who has custody? _____

CONSENT FOR TREATMENT

I hereby attest that I am voluntarily establishing my dependent with Beyond Speech Therapy, Inc., and give my consent for the minor under my legal guardianship to receive speech language pathology services at Beyond Speech Therapy. I understand that I may terminate these services at any time by verbal or written notice.

**If parents are divorced and share custody, both parents must sign the consent to treat.*

_____	_____	_____
Parent/Guardian Printed Name	**Parent/Guardian Signature**	**Date**
_____	_____	_____
Parent/Guardian Printed Name	**Parent/Guardian Signature**	**Date**

PRIMARY CONTACT FOR SCHEDULING AND BILLING

First Name: _____Last Name: _____ Relationship: _____

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

Email: _____

First Name: _____ Last Name: _____ Relationship: _____

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

Emergency Contact: _____ Phone: _____ Relationship: _____

HISTORY & CONCERNS

Previous speech therapy evaluation/s (list): _____

Other therapies to date (list): _____

Please describe concerns regarding your child's area of need:

_____

_____

Who noted the present concern? _____When? _____

What is your child's reaction to the concern? _____

How does the family react to the concern? _____

Any significant changes in the last six months? _____ If so, what? _____

How well is your child understood by others? i.e., what percentage of the time? 10%, 20%, 50% etc. _____

Parents		Teachers		Siblings		Extended Family		Unfamiliar Adults		Other children	

Describe what it is like to have a conversation with your child: _____

CURRENT GENERAL HEALTH

Has your child had chronic earaches/ear infections (more than 4 in 12 months)? Yes_____ No_____ Ear Tubes? _____

If chronic, please explain frequency here: _____

Allergies? Yes_____ No_____ If Yes, list: _____

Any other serious or recurrent illnesses? _____

Any operations? Yes _____ NO_____ If yes, please describe_____

Any accidents/falls involving trauma to the head or concussions? _____ If so, when did they occur? _____

Current medications and vitamins/supplements with dosage (a preprinted list is also acceptable): _____

_____

MEDICAL HISTORY

Seizures		High Fevers		Pneumonia		Asthma		Croup		Whooping Cough		Chronic Ear Infections	
Chicken Pox		RSV		Tonsilitis		Chronic Colds		Thyroid Issues		Sinus Infections		Encephalitis	

Please indicate if your child has had any of the following by writing their age of onset in the appropriate box. If not applicable, please leave box blank.

Vision Deficits		Glasses		Contact Lenses		Hearing Deficits		Hearing Aids		Dental Issues		Braces		Retainer		Oral Expander	

Any Operations? If yes, please list with dates: _____

Other Medical History not listed above: _____

Are standard immunizations current? Yes____ No____ (COVID vaccine NOT included as standard immunization)

Have you traveled outside the U.S. within the past 60 days? _____If so, where? _____

DEVELOPMENTAL HISTORY

Full Term (37+ wks) _____ Preemie _____ Weeks Early? _____ N.I.C.U.- Yes_____ No_____ Birth Weight: _____

Delivery: Vaginal_____ Cesarean_____ Breech (Feet First) _____ Head-First _____ Respiratory Issues at Birth: _____

Intubation or C Pap required? _____ Birth Hospital: _____ State: _____

Illnesses or accidents during pregnancy or Other unusual conditions or events that may have affected pregnancy or birth.

_____

Use or exposure to alcohol, tobacco, drugs or medications during pregnancy: _____

Age when child _____: (If you are unable to remember, note if it occurred at the Typical (T) time or if it was delayed (D).)

Sat Up Alone		Crawled		Dressed Independently	
Toilet Trained		Walked		Tied Shoes	

Is your child left or right-handed?

_____ Daily Nap? _____ Typical Bedtime? _____

LANGUAGE DEVELOPMENT HISTORY

Age child spoke:

Spoke First Word		Combined Words		Spoke in Sentences	

Child's first word(s)? _____

Which sounds (if any) are of concern? _____

How many words can your child say? _____ (List if fewer than fifteen) _____

_____

Any speech or hearing problems in the immediate or extended family (explain)? _____

_____

SCHOOL HISTORY

Child's Current School: _____ Grade: _____ Teacher: _____

School Services? Yes_____ No____ Current 504, IFSP or IEP? _____ (If so, please provide a copy for our records)

Receiving Services from Tri-Counties? _____ If yes, please indicate which services: PT ___ OT___ ST ___ EI___ ABA___

Who is your child's case manager? _____ Phone: _____

If receiving ABA services, who is your ABA therapist? _____ Phone: _____

How would you describe your child's academic performance? _____

Concerns expressed from teacher/school staff? Yes_____ No_____ If so, explain: _____

_____

SOCIAL/EMOTIONAL HISTORY

Please circle your responses

Does your child respond typically to?			
Light	Sound	Familiar People	Strangers

Does your child play with?			
Friends	Family	Unfamiliar Kids	Adults

Does your child have difficulty with?			
Sleeping Issues	Paying Attention	Transitions	Having Dirty Hands
Sitting Still	Eating/ Feeding	Brushing Teeth, Hair, Bathing, etc	Loud Sounds

Does your child?			
Cry Appropriately	Stay Focused	Smile/ Laugh	Get Upset Easily
Perseverate on Activities	Follow Directions	Understand You	Self Calm

Make wants/needs known? _____ How? _____

Does your child exhibit unusual behavior/s(explain)? _____

Names and ages of siblings: _____

Moves prior to age 10: _____ Does your child acclimate easily to change? _____

Number of regular playmates: _____ Age Range: _____ Does your child play with well with: Boys_____ Girls_____

Is your child able to manage?

Frustration/Conflict		**Separation**		**Unfamiliar People**	
Favorite Places		**Responsibilities**		**Last minute Changes**	

Minutes/Hours of daily screen time including schoolwork (TV, Computer, Ipad, phone, Xbox etc) _____

What motivates your child most? _____

What discipline methods work best? _____

PARENT GOALS AND EXPECTATIONS

What do you hope to achieve from this evaluation and Speech Pathology Services? _____

_____

Anything else you would like us to know? _____

_____

HOW DID YOU HEAR ABOUT US?

Friend_____ Family Member____ Radio____ Magazine_____ Website _____ Facebook _____ Physician _____ Other_____

Were you referred by your physician or self-referred? _____

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: _____

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 Policyholder/Guarantor: _____ Date: _____

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.

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. Payment for services is due at the time of service. 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, BST will bill your insurance provider and if benefits and coverage are approved, you will receive payment directly from your insurance provider via check by mail.
- 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. I also understand that if insurance does not pay for my claims, I am responsible for payment.

_____**ATTENDANCE POLICY**

I understand that my child 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.

_____**CANCELLATION/NO SHOW 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

- **Completed 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."
- **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." 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 Fees**
  Insurance will NOT pay for No show/cancellation fees. This fee must be paid before the next scheduled appointment.

_____**DROP OFF POLICY**

- Clients 6 years of age and younger or clients who may require toileting assistance, may NOT be "dropped" off by consenting parent/guardian. Parent/Guardian must be present in the clinic or parking lot while the child is in their appointment to be available for toileting assistance.
- 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.

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 lose desired days and times.
- If it is determined that continued participation will be a detriment to the child and/or their family, services may be terminated.
- Due to the importance of continuity of care, regular attendance at 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 exhibit harmful, threatening, or inappropriate behavior, Beyond Speech Therapy staff reserve 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.

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 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 acted 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 (if over 18 years or emancipated): _____ Date: _____

For minors- Legal Guardian 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.

Client Signature (if over 18 years or emancipated): _____Date: _____

For minors- Legal Guardian Signature: _____ Date: _____

ADDITIONAL SERVICES/RATES NOT COVERED BY INSURANCE

- $115.00 per 30 min – Consultation (minor/client not present)
- $115.00- per 30 min- Attendance to IEP meeting via phone or zoom (Therapist will not attend in person)
- $225.00- per 60 min- Attendance to IEP meeting via phone or zoom (Therapist will not attend in person)

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 by patient or patient's guarantor only
- Courtesy File sharing between all providers involved in patient's plan of care (By Fax Only- Paper Requests will incur charges above