More Than Words… Therapy Services, LLC
215-A Dunbar Cave Rd | Clarksville, TN 37043
Telephone: 931.542.2739 | Fax: 931.233.9970
Website: www.MoreThanWordsLLC.com
Facebook: MoreThanWordsTherapy

Dear Parents:

Thank you for choosing *More Than Words…Therapy Services* for your child's therapy. We are honored to be able to help your child and family achieve your goals. In order to help all of us develop the best working relationship possible, we would like to begin with clear communication about our business regarding our responsibilities to you, our clinical/business practices, business policies and clinical expectations. In this 1st Therapy Session Packet, you will find the following policies for you to read and sign.

INFORMATION FORMS IN THIS PACKET:

- Billing Policy
- Cancellation/No Show/Tardiness Policy
- Scheduling and Phone Calls Policy

Please note that your first session with your child's therapist is typically 1 hour long. This amount of time allows you to read through the policies and to voice any questions or concerns you may have about the policies to your therapist.

In addition, this time period allows your therapist ample time to evaluate your child and to review your child's evaluation results with you. If the evaluation runs the full hour, the review may be postponed until the following session due to time constraints. Your therapist can answer any questions you may still have about the evaluation. Your therapist may want to review some of the basic teaching that occurred during the evaluation to make sure you are comfortable with the information. Your therapist will want to follow-up with regards to how everyone is doing with the recommendations from the evaluation as well.

The first therapy session is an opportunity for your therapist to get to know you and your child better through beginning your clinical work together. The first goal of this session will be to begin building a trusting relationship between the therapist and your child by teaching a treatment session routine to your child (with explanations given to you as the session progresses). The direct clinical treatment at the first session will necessarily be shorter in duration than during other sessions, due to the extra teaching time needed.

We hope the information in this packet will be informative. Please read all pages thoroughly and sign any forms where appropriate.

Thank You Very Much!

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Patient Registration

Patient information

Patient First and Last Name _____ Female____ Male____ Birthdate_____

Parent or Guardian _____

Address _____

City, State, Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email address_____

Insurance information

Insured First and Last Name: _____ Insured DOB: _____

Employer _____

Insurance _____ Insurance Phone _____

Insurance Address: _____

Insurance City, State, Zip Code_____

Social Security _____ Policy Number _____

Group Number _____

Billing Address (if different from above) _____

Medical information

Referring Physician _____ Physician's Phone _____

Physician Address _____

How did you hear about More Than Words…Therapy Services? _____

_____ _____

Signature **Date**

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Parent or legal guardian informed consent for services

I consent for my child to receive evaluation and/or therapy services from More Than Words-Speech and Feeding Therapy, LLC and their treating therapists according to my child's physician's orders. I understand that More Than Words-Speech and Feeding Therapy, LLC. will bill my insurance company first. If the service is not covered by my insurance, I agree to pay for the service in-full immediately upon receiving a bill from More Than Words-Speech and Feeding Therapy, LLC. If my child has TN Medicaid, MTW will accept the reimbursement as payment in full. I also understand that it is my responsibility to keep my child's insurance and/or Medicaid coverage in effect. I agree to inform MTW of any changes in my child's health insurance coverage. I understand that if I do not keep my insurance or Medicaid coverage in effect, and do not inform MTW, I agree to pay the usual and customary fee for services provided during the period without coverage. If the above named child needs emergency medical care while receiving services, I give permission for More Than Words-Speech and Feeding Therapy, LLC. or their treating therapists, to obtain such care, and I agree to be financially responsible for the services.

_____ _____

Print Child's Name **Date of Birth**

_____ _____

Parent of Legal Guardian Signature **Date**

Direct assignment of insurance payment

Please bill my insurance:

When More Than Words-Speech and Feeding Therapy, LLC. files for third party payment under my policy benefits, and they are otherwise payable to me as the policyholder, I authorize payment directly to More Than Words-Speech and Feeding Therapy, LLC. If my policy prohibits direct payment to a doctor or treatment facility, the payment should be made to me as the policyholder, and I agree to reimburse the full amount to More Than Words-Speech and Feeding Therapy, LLC. This is a direct assignment of rights and benefits under my insurance policy. I agree to pay to More Than Words-Speech and Feeding Therapy, LLC., in a timely manner, any balance that remains after payment of insurance benefits. A photocopy of this assignment shall be considered as effective as the original.

I have read and understand all of the above, and I agree to all of the conditions and information. I understand that this agreement will remain in effect the duration of treatment, and that I can revoke this agreement at any time in writing, except for services that have already been provided.

_____ _____

Policyholder/Legal Guardian Responsible for Payment **Date**

Direct Billing

(Sign the following section **ONLY** if you will to be personally billed for the services; otherwise, leave blank.)

I request that I, in accordance with the Health Insurance Portability and Accountability of 1997 ("HIPPA"), 45CFS 164.522 that More Than Words-Speech and Feeding Therapy, LLC. NOT contact my insurance carrier. In doing so, I understand that the policy benefits will not apply to my charge for the services and that I WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICES. PLEASE BILL ME PERSONALLY AT THE TIME THAT SERVICES ARE RENDERED.

_____ _____

Policyholder/Legal Guardian Responsible for Payment **Date**

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Collections

In the event of default, responsible party will be responsible for all collection and/or attorney fees association with collections.

_____ _____

Policyholder/Legal Guardian Responsible for Payment **Date**

IEP (Individualized Education Plan)

All patients with Tricare over the age of 3 are required to submit a current IEP to MTW. IEP's can be obtained through the school system. Failure to have current IEP on file may result in services being denied through Tricare and responsibility to cure payment would go to the Policyholder / Legal Guardian. If you have additional questions please let us know.

School System: _____

Current IEP: _____ Yes (Please provide copy at your next visit) _____ No _____ In Process

If no or in process, please explain status: _____

_____ _____

Parent or Legal Guardian Signature **Date**

Acknowledgment of privacy notice and client privacy rights

As a client of MTW, you have certain rights regarding your child's services and the protection of your/your child's health care information. "Notice of Privacy Practices" has been given to you today.

_____ _____

Parent of Legal Guardian Signature **Date**

If we are unable to speak with you directly by phone, is it okay for us to leave detailed/ clinical information on your answering machine, if available?

☐ YES ☐ NO

If the signature above is not the patient, please state your relationship to the patient.

Relationship to patient: _____

_____ _____

Parent or Legal Guardian Signature **Date**

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Cancellation / No Show / Tardiness Policies

Dear Parents,

Thank you for choosing More Than Words Speech & Feeding Therapy, LLC. for your child's care. The policies written below are designed to improve our ability to see all of our patients, and to provide complete, consistent treatment for your child. We hope that these policies will improve our overall service to our patients. Since continuity of care is important to maximize the outcomes of your child's therapy, we use the following guidelines for your appointments:

1. Therapists often are not able to wait more than 15 minutes for a late appointment. Please notify your therapist as soon as you know you will be late. Because of scheduling constraints, late arrivals may not be able to be seen, and if seen, the session will end at the regularly scheduled time. If you are late without notification and your therapist needs to see your child for a shorter amount of time, you will be charged for the entire scheduled session.

2. If you need to cancel your child's appointment, our Clinic requires that you cancel 24 hours in advance of the scheduled appointment time. You will be charged **$25.00**, except in emergency situations, if we have not received the 24 hour notification. Please note that this cancellation fee will not be billed to your Insurance, and so will need to be paid for directly by you.

3. If you have three consecutive cancellations and/or consistent rescheduling of your child's appointments or you miss more than ½ of your scheduled appointments, you may lose your standing appointment time slot. Additionally, your child may be placed on hold for therapy. You and your child's primary care physician will be notified by phone or letter of such circumstances.

4. If your child does not attend their scheduled appointment, and you have not called to give any type of notification that the session was going to be missed, you will be considered to be a "No Show" for treatment. Additionally, you will be charged **$25.00** for the scheduled therapy appointment, which was missed. If you have two "No Shows" for scheduled appointments, your child's therapy will be put on hold, and you and your child's primary care physician will be notified.

Please feel free to speak with your therapist about any concerns you may have about these policies, or to discuss changing your regularly scheduled appointment time if you know that your current scheduled time is not optimal. We will do everything possible to provide you with a time that is consistently available for both you and your therapist. Thank you for your cooperation.

_____

Patient's Name

_____ _____

Policyholder/Legal Guardian Responsible for Payment **Date**

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Release of information

I authorize More Than Words-Speech and Feeding Therapy, LLC. and/or their treating therapists to obtain/release information, as necessary, for the purpose of filing for insurance compensation or for requesting compensation from Federal or State resources that appropriate payment for services that my child receives. I understand that in order for my child to be provided with the best possible services, MTW must have my permission to communicate with other providers involved in my child's care. I hereby grant permission for MTW and their treating therapists to obtain/share information with the following agencies/persons: *(Please list the names of all physicians, practices, and agencies that are involved in your child's care.)*

Primary Physician/Practice name:_____

Other Current Service Provider:_____

Physicians/Specialists:_____

Children's Developmental Services Agency:_____

School System:_____

Other:_____

_____
Patient's Name

_____ _____
Parent or Legal Guardian Signature **Date**

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AND/OR YOUR CHILD 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.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, therapist, 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 healthcare bills, to support the operations of the 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/ payment for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval/ payment for the treatment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our 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 in 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 treating provider. We may also call you by name in the waiting room when your provider 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 Disease Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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Other permitted and required uses and disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician, provider, or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

HIPAA Notice of Privacy Practices (cont.)

YOUR RIGHTS – Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician/ provider is NOT required to agree to a restriction that you may request. If the physician/ provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician/ provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you via mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your provider of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before July 1, 2003.