RAINBOW SKIES SPEECH-LANGUAGE THERAPY, LLC

Dear Parents,

Welcome to Rainbow Skies Speech-Language Therapy! To best get started with speech therapy services including screening, evaluation, and treatment, we ask that you submit the following initial paperwork:

1. A copy of the front and back of the patient's insurance card along with the patient's & policy holders names & dates of birth.

2. Signed copies of the following forms:

   - Case History Form (Please complete the Case History Form to the best of your ability. This will help us better understand the needs of your child.)
   - Consent for Release of Information
   - HIPPA Authorization
   - Payment Policy & Agreement
   - Cancellation Policy
   - Credit Card Charge Authorization Form

You may Email: tkokot28@optonline.net with all completed and signed initial paperwork or bring it to your scheduled appointment.

We look forward to working together with you and to helping your child's communication skills improve and flourish. Please do not hesitate to call us at (732)740-9940 if you have any questions about the required forms or about our speech therapy services in general.

RAINBOW SKIES SPEECH-LANGUAGE THERAPY, LLC

PAYMENT POLICY & AGREEMENT

1. **Payment:** We currently participate in most major insurance plans. For your convenience, we will file insurance claims to your insurance carrier. If we do not accept your insurance plan, payment is expected in full at each visit.
2. **Co-payments and deductibles**: All co-payments and deductibles must be paid at the time of service This arrangement is part of your contract with your insurance company.
3. **Claims Submissions:** We will submit your claims and assist you in any way reasonably possible to help get your claims paid. However, knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage for Speech Therapy. For instance, the number of visit limitations, diagnosis covered, and what requirements they may have to ensure proper payment (i.e., referral, RX, letter of medical necessity, etc.).
4. **Additional Information**: Occasionally, your insurance company may ask you directly to supply additional information. When requested, we will assist you in providing necessary information, but it is ultimately your responsibility to honor the insurance carriers request. Please note that the balance of your claim is your responsibility.
5. **Please inform the office of any changes in your insurance coverage.** If your insurance has changed or is terminated at the time of service, you will be held financially responsible for the balance in full.
6. **Non-covered Services**: Please note that some, or perhaps all the services you receive may not be covered by your insurance carriers. Insurance carriers and their policies differ widely in terms of which diagnosis and procedures they will cover. We will work with you to determine what your policy will cover, but it is your responsibility to ensure that your policy will cover the specific diagnosis provided for your child. Any non-covered procedures or services are your responsibility.

I ________________________________, have read Rainbow Skies Speech-Language Therapy policy regarding insurance and payment and I accept all terms and conditions.

Signed: _____________________________________ Date: ____________________

833 Monmouth Road, Cream Ridge, NJ 08514 Phone: 732-740-9940
tkokot28@optonline.net www.rainbowskiesspeechtherapy.com

RAINBOW SKIES SPEECH-LANGUAGE THERAPY, LLC

CANCELLATION & NO-SHOW POLICY

We kindly request that if you are unable to keep your appointment or need to reschedule, **please contact us at least 24 hours prior to your appointment**. Failure to call or be present for an appointment is considered a missed appointment. Rainbow Skies Speech-Language Therapy will charge the patient or the responsible parent/guardian the rate of a normal visit for all missed appointments. Please note that insurance providers do NOT reimburse for missed appointment charges. If your child consistently misses 3 or more therapy sessions, Rainbow Skies Speech-Language Therapy reserves the right to place your child's services on hold until scheduling conflicts are resolved. A consistent schedule is pertinent to your child's progress in speech-language therapy. Please help us serve you better by keeping scheduled appointments.

We understand that weather, isolated events and illness can occur unexpectedly and will take that into consideration before charging a fee.

Illness Policy: If your child has a fever, a persistent cough, or a runny nose, please call, and cancel your appointment. Due to the therapist working near your child's face, it is easy for the virus to be spread. Your therapist needs to see many children over the course of the week and cannot afford to be out sick frequently. A general rule of thumb is that if a child has been on an antibiotic for 24 hours and does not have a fever, is not coughing frequently, and does not have a runny nose, he/she is probably not contagious. We appreciate your understanding and will be happy to reschedule your appointment.

How to Cancel Your Appointment: To cancel appointments, please text or call (732) 740-9940. If you do not reach someone in person, please leave a message on the voicemail. You may also email: tkokot28@optonline.net.

I have read and accept all policies pertaining to missed appointments, illness, and inclement weather.

Signed: ______________________________________ Date: ____________________

HIPPA PRIVACY POLICY

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR MEDICAL INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Rainbow Skies Speech-Language Therapy, LLC is required by law to keep your health information safe. This information may include your:

- medical history
- treatment notes
- evaluation/test results
- information provided by your doctors/teachers/health care providers
- insurance information

The Health Insurance Portability and Accountability Act, or HIPAA, requires that Speech-Language Therapy, LLC provides you with a copy of this privacy notice. We will ask you to acknowledge that you have received and read this notice.

You may refer to this notice any time to see how your health information may be used and who may be entitled to see it.

How Your Health Information May Be Used or Shared

Rainbow Skies Speech- Language Therapy, LLC may use or share your health information *without* your permission for the following reasons:

- **Treatment**- We may share your information with doctors and other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of your treatment with that doctor.
- **Payment-** We may use and share your health information about the treatment you receive with your insurance company or other payer to receive payment for services. This may include sharing important medical information. We may share health information to obtain the insurance company's permission to start treatment; obtain permission for additional treatment; or get reimbursed for treatment you received

YOUR HEALTH INFORMATION MAY ALSO BE USED OR SHARED WITHOUT YOUR PERMISSION FOR:

- **Abuse and Neglect**: We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders**: We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by e-mail, or by phone call, voicemail or text message. If you do not wish to get reminders, please notify your speech-language pathologist.
- **As Required by Law**: We will share your information when we are told to do so by federal, state, or local law. We will also share information if we are asked by the police or courts.
- **Government Function**: Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- **Information About a Person Who Has Died**: We may share your information with the coroner, medical examiner, or a funeral director as needed.
- **Public Health Risks**: We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases or infections.
- **Regulatory Oversight.** We may use or share your information with agencies overseeing health care. This may include sharing information for audits, licensure and inspections.
- **Workers' Compensation.** If your treatment is related to a work-accident, we may share your information with the Department of Industrial Accidents, your workers' compensation insurance company and/or your employer.

WHEN YOUR PERMISSION IS NEEDED TO USE OR SHARE YOUR HEALTH INFORMATION

You must give us your permission to share your health information for any situation this is not listed in this notice. You will be asked to sign an authorization, allowing Rainbow Skies Speech-Language Therapy, LLC to share your information. You can revoke the authorization at any time Once your information is released, we cannot retrieve it back from the release.

YOUR PRIVACY RIGHTS

You have the right to:

Ask us not to share your information: You can ask us not to use or share your information for treatment, payment or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.

Ask us to contact you privately: You can ask us to contact you only in a certain way or at a certain place. For example, you may want us to call you but not e-mail you. Or you may want us to call you at work but not at home. Limitations on contact must be in writing.

Look at and obtain a copy of your health information: You have the right to see your health information and to get a copy of your health information at any time. You have a right to see your treatment, medical and billing information. Requests for copies of your health information must be made in writing and we will provide you with a copy of the requested information within a reasonable time. You may not be able to see or copy information put together for a legal proceeding, certain lab results and/or copyrighted materials, such as test protocols.

Ask for changes to your health information: You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must make these requests in writing and provide a reason for the request. Rainbow Skies Speech-Language Therapy, LLC retains sole discretion in making any requested change to your health information.

Get a report of how and when your information was used or shared: You can ask us to tell you when your information was shared and who it was shared with. The request must:

- be made in writing.
- indicate the dates you are inquiring about.
- indicate whether you want to be notified via mail or e-mail.
- be for a period within the last six (6) years.

Get a paper copy of this Privacy Notice: You may receive another copy of this notice at any time.

File Complaints: You will not be penalized for filing a Complaint. All complaints must be in writing. You can file a Complaint with us or with the government if you believe that:

- Your information was used or shared in a manner that is not allowed.
- You were not allowed to look at or obtain a copy of your health information.
- Any of your rights were denied.

WHO IS COVERED BY THIS NOTICE: The people who must follow the rules in this notice are:

- All speech-language pathologists working at Rainbow Skies Speech-Language Therapy, LLC.
- Anyone who is able to add health information to your file, including office staff.
- Any students or volunteers who may help you while you are at this private practice.

CHANGES TO INFORMATION IN THIS NOTICE: We may change or amend this notice and its content at any time. Changes may apply to information we already have in your file and to any future information. Copies of the current notice will be posted in our office and/or made available to you, upon your request, from our staff. The amended notice will have the date on the front page indicating when it went into effect.

CONTACTS: If you have any questions about this notice or your privacy rights, please ask your speech-language pathologist.

HIPPA AUTHORIZATION

I understand that as part of my health care, Rainbow Skies Speech-Language Therapy, LLC, maintains records about my health as related to my speech, language, hearing and/or swallowing abilities and is required by law to keep your health information private. This information may include:

- Notes from your doctor
- Your medical history
- Your evaluation results
- Treatment Notes
- Insurance Information

The attached Notice of Privacy Practices gives a more complete description of how my health information may be used or disclosed by Rainbow Skies Speech-Language Therapy, LLC. The Notice of Privacy Practices also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.

I have been provided a Notice of Privacy Practices and have been given the opportunity to review this information.

By signing this page, you are acknowledging that you have been given a copy of our privacy notice. Please retain a copy of this privacy notice for your records.

Clients Name: ____

Client's D.O.B.: ____

Parent/Guardian Name: ____

Parent Signature: ____

Date: ____

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RAINBOW SKIES SPEECH-LANGUAGE THERAPY, LLC

CREDIT CARD CHARGE AUTHORIZATION FORM

I authorize Rainbow Skies Speech-Language Therapy, LLC to charge the below-referenced credit card for services rendered and any related expenses (co-pay/co-insurance/deductible or session fee). In addition, I understand my credit card will be charged if:

- I do not pay my invoice in full on the date it is due.
- Proper cancellation procedures are not followed as noted in the Cancellation and No Show Policy.
- A check is returned for insufficient funds (fee of $25.00)
- At discharge, if an account balance remains, your credit card will be charged for unpaid services to discharge date.

I, the undersigned, further understand it is my responsibility to inform Rainbow Skies Speech-Language Therapy, LLC of any changes to my credit card information including address, zip code, updated expiration dates, account numbers and security codes.

PLEASE PRINT CLEARLY; CIRCLE ONE CREDIT CARD BELOW:

VISA MASTER CARD DISCOVER AMERICAN EXPRESS

Account No. ____
Expiration Date: ____________ Security Code:_____________________
Name as it appears on Credit Card: ______________________________

Signature_________________________________ Date____________________________

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RAINBOW SKIES SPEECH-LANGUAGE THERAPY, LLC

AUTHORIZATION TO RELEASE INFORMATION

I, ________________________, hereby authorize, Rainbow Skies Speech-Language Therapy, LLC
(Parent/Guardian)
to use, disclose and/or discuss protected health information from my medical record to those listed below. I understand the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting confidentiality.

Name/Title	Address	Phone	Email

Rainbow Skies Speech-Language Therapy, LLC is authorized to disclose/discuss the following information, including but not limited to: medical records, evaluation results, and treatment records (i.e. progress notes, daily session notes) as it relates to therapy/treatment and evaluations at this practice. This information may be used or shared for medical, insurance, legal, and/or educational purposes.

I understand that I may revoke this authorization at any time by requesting to Rainbow Skies Speech-Language Therapy, LLC in writing.

____________________________________ ____________________________________
Parent/Guardian Signature Date

____________________________________ ____________________________________
Parent/Guardian (Printed) Client Name (Printed)