SPEECH THERAPY PLUS, INC.

PROVIDING SPEECH AND OCCUPATIONAL THERAPY SERVICES

0ffice #: 252-633-6770 Fax #: 877-335-6220

speechtherapyplus@tritxsoapnotes.com

PLEASE RETURN PARENT PACKET TO:
1702 D HWY 70 EAST
NEW BERN, NC 28560

Dear Parent or Guardian,

We received a referral for your child for speech and/or occupational therapy services; we require certain consents and social history forms to initiate services. You have opted to completed and sign our parent packet forms electronically. The first consent form you will receive allows for this exchange via e-mail and using Echosign for authenticating your signatures for consents. Upon completion of the paperwork, you and the office of Speech Therapy Plus will receive a signed and complete copy of the forms for record keeping via an e-mail. Once the forms have been completed and electronically signed, we will initiate services. Please know that from the time we receive the complete packet of information, it could take a few weeks for our office to obtain a doctor's order, notify the insurance company, review any cost the family may be responsible for, and set up the referral for the therapist to begin services.

Also provided is a copy of our "Notice of Privacy Practices" for your records. The privacy notice is similar to the privacy notice you would receive from any medical or pharmacy facility.

If you have any questions or wish to decline completing these forms electronically, please contact our office via phone or through email and we are happy to mail these forms directly with an addressed envelope for you to return them.

Sincerely,
Kayse Henry, MS, CCC-SLP

E-mail: speechtherapyplus@tritxsoapnotescom/Office: 252-633-6770/ Fax: 877-335-6220

CONSENT AND AUTHORIZATION TO EXCHANGE INFORMATION VIA EMAIL AND ACKNOWLEDGEMENT THAT THESE EMAILS MAY CONTAIN PROTECTED AND INDIVIDUALLY IDENTIFIABLE HEALTH OR EDUCATIONAL INFORMATION.

SUPPLEMENTAL CONSENT FORM FOR:

Child's Name____ DOB____________________

IMPORTANT NOTIFICATIONS AND DEFINITIONS

****The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. FERPA gives parents certain rights with respec to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level.***

****The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Privacy Rule standards address the use and disclosure of individuals' health information. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, insurance information, etc.)***

CONDITIONS FOR USE OF EMAIL

Speech Therapy Plus, Inc. is requesting your consent to exchange information and to communicate information about your child through electronic mail. Speech Therapy Plus cannot guarantee but will use reasonable means to maintain security and confidentiality of electronic information sent and received. Speech Therap Plus, Inc. uses Google Apps for Business and Echosign for electronic sign**atures. This consent is completely voluntary and can be revoked at any time. This consent will automatically expire at your request or at the time of your child's discharge from services with Speech Therapy Plus.**

1. This supplemental consent form allows for Speech Therapy Plus, It's office staff, and therapist to exchange information about your child via email.
2. This consent form allows for you to request information from Speech Therapy Plus, Inc via email.
3. Communications via email could include, but are not limited to: signatures needed, paperwork needed, request to update information, scheduling, copies of reports, progress, doctor's orders, billing, prior approval through your insurance, education, continuity of care with schools, pediatrician's, head starts, etc.
4. You must notify us of information you do not feel is appropriate for email. Please list below:

____

5. You must notify us of a change in your email address by requesting a new consent form either by email or in writing.

RISKS OF USING EMAIL

Although Speech Therapy Plus, Inc. makes every attempt to keeping all Protected Health Information (PHI) AND Educational Records safe and confidential. There are some risks to transmitting information by email that you should consider.

1. E-mails can be intercepted, altered, forwarded, or used without authorization or detection.
2. E-mails can be circulated, forwarded, and stored in paper and electronic files.
3. E-mail senders can easily type in the wrong e-mail address by accident.
4. E-mail may be lost due to technical failure during composition, transmission, and/or storage.

PARENT ACKNOWLEDGEMENT AND AGREEMENT

I have read and fully understand the information in the authorization form. I understand the privacy risks associated with use of e-mail communications. I understand that I have the right to revoke this consent, in writing, at any time. I understand that I must take precautions to preserve the confidentiality of my email account and access to it's contents by unauthorized users by making sure access is restricted and the account is password protected.

____ **YES,** I AUTHORIZE SPEECH THERAPY PLUS TO USE MY EMAIL ADDRESS FOR COMMUNICATION PURPOSES LISTED ABOVE. THE EMAIL ADDRESS I AUTHORIZE TO BE USED IS:

WHO'S NAME IS ON THE EMAIL ACCOUNT YOU ARE AUTHORIZING:

____

EMAIL ADDRESS: ____

Parent/Legal Guardian's signature:____

Date Consent is signed: _________________

Speech Therapy Plus, Inc.
Notice of Privacy Practices

This Notice Describes How Medical Information About Your Child May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

This Notice is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This notice describes how we may use and disclose your child's protected health information (PHI) to carry out treatment, payment, and healthcare operations and for other purposes that are permitted or required by law. PHI includes any of your child's written or oral health information including demographic data that can be used to identify your child. This is PHI that is created or received by Speech Therapy Plus, Inc. and/or its agent.

Understanding Your Child's Health Information

Each time your child receives health related services a record is made of the treatment. Typically, this record contains the child's diagnosis and treatment notes. This information, often referred to as a health, treatment or medical record, serves as a:

- Basis for planning your child's care
- Means of communicating among the health professionals (physician) who contribute to your child care
- Legal document describing the care your child received
- Means by which you or a third-party payer (Medicaid OR other Health Insurance) can verify that services billed were actually provided

Your Child's Health Information Rights

Although your child's health record is the physical property of the facility, in this case, Speech Therapy Providers, Inc., the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your child's information as provided by 45 CFR 164.522
- Receive confidential communications of protected health information as provided by 45 CRF 164.522
- Inspect and copy your child's health record as provided for in 45 CFR 164.522
- Request to amend your child's health record as provided in 45 CRF 164.522
- Obtain an accounting of disclosures of your child's health information as provided in 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Obtain a paper copy of the notice from us upon request

The right to make a request does not guarantee it will be granted, the request may be denied based on certain situations; including, emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, for example. All requests must be made in writing and mailed OR emailed to: Speech Therapy Plus, Inc.

1702 D HWY 70 EAST
NEW BERN, NC 28560
speechtherapyplus@tritxsoapnotes.com

Our Responsibilities

- Maintain the privacy of your child's protected health information (PHI)
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction

We will not use or disclose your child's health information without your authorization, except as described in this notice:

We will use your child's health information <u>for treatment</u>.

For example, information obtained by our health related services provider, speech language pathologist or occupational therapist, will be recorded in your child's record and used to determine the best plan of care for your child.

We will use your child's health information <u>for payment</u>.

We may use and give your child's health information to electronically bill Medicaid and collect payment for treatment services provided to your child by us or a contracted agent. Speech Therapy Plus, Inc is approved participating group provider of Medicaid. Medicaid only approved us as providers after making sure in writing that we as providers will safeguard your information in the same way Medicaid does.

PLEASE KEEP THIS COPY FOR YOUR RECORDS—DO NOT RETURN!

SPEECH THERAPY PLUS, INC.

"FOCUSED ON THE CLIENT'S INDIVIDUAL NEEDS"

speechtherapyplus@tritxsoapnotes.com

Office: 252-633-6770/ Fax: 877-335-6220

CONSENT AND AUTHORIZATION TO TREAT AND EXCHANGE INFORMATION

Child's Name_________________________________ DOB_________ Medicaid#_____________________

Other Insurance Name___________________________________ Insurance # __________________________

Parent/Guardian's Name _____________________________________ Phone# _________________________

Address ____ County _______________________

As the parent/legal guardian of the above named child I give ***SPEECH THERAPY PLUS, INC*** permission to do the following in reference to the above named child:

- Perform a formal **speech/occupational** evaluation
- Provide **speech/occupational therapy** treatment as needed
- Bill Medicaid/or other insurance company listed above for payment electronically for all services to be paid directly to ***SPEECH THERAPY PLUS, INC.***
- Provide copies of all EOBs from health insurance company to Speech Therapy Plus, Inc. to ensure accurate billing and payments.
- Release any information needed to Medicaid-Raleigh/ insurance company listed above in order to receive payment for services.
- Release ***and/or*** exchange ***any*** relevant information with the agencies/facilities listed below about the above named patient for assessment/treatment/payment purposes.

Agencies/Facilities *(Please add/delete any agency you do/do not want to have access to the child's health information) YOU MAY MARK THROUGH AND INITIAL ANY THAT YOU WOULD LIKE EXCLUDED OR WRITE IN THE NAMES OF OTHER INDIVIDUALS YOU WOULD LIKE INCLUDED.*

AGENCIES/FACILITIES TO RELEASE AND/OR EXCHANGE INFORMATION WITH:

Other agencies/facilities to release and/or exchange information with:

__X__ Health Insurance Company __X__ Speech Therapy Plus, Inc. __X__ Public School/Head Start in County of Residence
__X__ PEDIATRICIAN - MY PEDIATRICIAN IS AT THE FOLLOWING OFFICE:

____

OTHER: ____

By providing my signature below, I understand and agree with all of the above and understand that the consent given is completely voluntary and can be revoked at any time, except for any action that has been taken prior to the date the consent is revoked. I UNDERSTAND THAT THIS CONSENT WILL EXPIRE WHEN MY CHILD IS DISCHARGED BY SPEECH THERAPY PLUS, INC OR UPON WRITTEN REQUEST TO REVOKE THIS CONSENT. I also understand that my signature acknowledges that I have been provided a copy of Speech Therapy Plus, Inc. Notice of Privacy Practices and that the notice is the result of federal regulation cited under the Health Insurance Portability and Accountability Act (HIPPA), effective 4-14-03, stating all providers of health related services are required to provide individuals receiving treatment and having services electronically billed for treatment with a copy of the Notice of Privacy Practices regarding protected health information.

Parent/Legal Guardian's signature:____

Date Consent is signed: _______________________

PLEASE SIGN AN RETURN AS SOON AS POSSIBLE!

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PROVIDING SPEECH AND OCCUPATIONAL THERAPY SERVICES

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: ______________________________________

Date of Birth: ____

I request and authorize: ***PLEASE WRITE NAME OF DOCTOR'S OFFICE***

____
__

I request and authorize: ***PLEASE WRITE NAME OF COUNTY FOR PUBLIC SCHOOL IEP RECORDS IF YOU CHILD HAS AN IEP.***

____

to release health care information for the patient named above to:
Speech Therapy Plus, Inc. via fax to 877-335-6220.

I have recently authorized Speech Therapy Plus, Inc permission to perform a Speech/Language and/or Occupational Therapy Evaluation and This request and authorization applies to health care information that may be needed as a part of the evaluation process. Please provide a copy of the following information:

____Physical Health Assessment including Hearing Screening Results

____Copy of IEP records including the most recent DEC 4 and DEC 3

Other: ____

Parent's Signature: ____

Date Signed: ____

PLEASE SIGN AND RETURN AS SOON AS POSSIBLE!

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"FOCUSED ON THE CLIENT'S INDIVIDUAL NEEDS"

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PERMISSION FOR CHILD TO RECEIVE EDIBLE TREATS

_____ YES, I give permission my child __________________________________ to receive edibles/treats before, during, and/or following therapy/evaluation sessions.

My child is **allergic to and/or is not allowed to eat** any of the following foods:____

_____ NO, I DO NOT give permission for employees of Speech Therapy Plus, Inc. to give my child (name listed above) treats following therapy/evaluation sessions.

Parent/Legal Guardian's signature:____

Date Consent is signed: _________________

SPEECH THERAPY PLUS, INC./ SOCIAL/DEVELOPMENT HISTORY

CHILD'S NAME__________________________________ DATE OF BIRTH _____________

PARENT/CAREGIVER COMPLETING FORM _________________________________ DATE_________

HAS YOUR CHILD EVER RECEIVED THERAPY BEFORE? _____YES OR ____NO

IF YES --WHAT TYPE? ___SPEECH___OT____PT WHERE? _________________________________

DOES YOUR CHILD **HAVE OR EVER** HAD AN IEP OR IFSP? ____YES OR ____NO

THINKING ABOUT YOUR PREGNANCY AND THE BIRTH OF THIS CHILD PLEASE CHECK ANY THAT APPLY?

	NORMAL PREGNANCY		HOSPITALIZED DURING PREGNANCY		MOTHER WAS UNDER CARE OF A DOCTOR FOR PREGNANCY
	BABY WAS PREMATURE		BABY WAS FULL-TERM		MOTHER CONSUMED ALCOHOL

PLEASE LIST ANY COMPLICATIONS AT BIRTH:

BABY'S CONDITION AT BIRTH:

MEETING DEVELOPMENTAL MILESTONES PLEASE CHECK THE APPROPRIATE BOX:

MILESTONE	WITHIN NORMAL LIMITS	LATER THAN EXPECTED
SIT ALONE		
STAND ALONE		
CRAWL ALONE		
WALK ALONE		
SPEAK FIRST WORDS		
SPEAK FIRST SENTENCES		

DOES YOUR CHILD HAVE A HISTORY OF CHRONIC EAR INFECTIONS OR TUBES PLEASE DESCRIBE:

DOES YOUR CHILD HAVE ANY HEALTH PROBLEMS?

DOES YOUR CHILD TAKE ANY MEDICATION ON A REGULAR BASIS? IF SO, PLEASE LIST.

PLEASE DESCRIBE WHAT YOUR CHILD CAN DO WELL:

WHAT IS YOUR PRIMARY CONCERN FOR YOUR CHILD:

IS THERE ANY OTHER INFORMATION THAT YOU THINK WOULD HELP US UNDERSTAND YOUR CHILD BETTER?

HAS YOUR CHILD HAD ANY OF THE FOLLOWING PROBLEMS OR IS THERE FAMILY HISTORY?

TYPE OF PROBLEM	YES OR NO	PLEASE DESCRIBE
HEALTH OR MEDICAL CONDITION THAT REQUIRED HOSPITALIZATION		
SURGERIES		
UNUSUAL ILLNESS,ACCIDENTS, OR HIGH FEVERS		
ALLERGIES		
POOR EATING HABITS		
POOR SLEEPING HABITS		
BEDWETTING		
CRYING SPELLS		
TEMPER TANTRUMS		
FAILURE AT SCHOOL		
HEARING /VISION PROBLEMS		
ADHD/ADD		
SOCIAL OR BEHAVIOR PROBLEMS		
LEARNING OR UNDERSTANDING		

BELOW PLEASE RATE YOUR CHILD COMPARED TO OTHER CHILDREN HIS/HER AGE:

	NOT AS WELL AS OTHER CHILDREN	THE SAME AS OTHER CHILDREN	BETTER THAN OTHER CHILDREN
ABILITY TO FOLLOW DIRECTIONS			
GETS ALONG WITH OTHER CHILDREN			
GETS ALONG WITH ADULTS			
LEVEL OF ACTIVIITY			
ATTENTIVENESS			
SPEECH			
COORDINATION (GROSS MOTOR)			
FINE MOTOR SKILLS (HANDWRITING, ETC.)			
INTEREST IN BOOKS			
SELF HELP SKILLS			

ONLY COMPLETE THE FOLLOWING FORM IF YOUR CHILD IS 5 YEARS OLD OR YOUNGER

PLEASE ANSWER YES OR NO FOR THESE ITEMS. THESE QUESTIONS RELATE TO WHAT YOUR CHILD CAN OR CANNOT UNDERSTAND WHEN SOMEONE IS TALKING TO HIM OR HER (AUDITORY COMPREHENSION) AND HOW WELL THEY CAN TELL YOU WHAT THEY KNOW (EXPRESSIVE COMMUNICATION):

MY CHILD IS ABLE TO:	YES OR NO	MY CHILD IS ABLE TO:	YES OR NO
Glances momentarily at a person who talks to him/her		Demonstrates appropriate use of objects in play	
Enjoys caregiver’s attention		Identifies photographs of familiar objects	
Reacts to sounds other than voices in the environment		Understands inhibitory words like “wait” and “stop”	
Looks intently at a speaker		Indicates body parts on self, caregiver, or teddy bear	
Turns head to locate the source of a sound		Understands verbs in context	
Actively searches to find a person who is talking		Identifies clothing items on self or caregiver	
Discriminates one sound from another		Understands spatial concepts (in, off, out of)	
Puts objects in the mouth		Recognizes actions in pictures	
Shakes and bangs objects in play		Understands several pronouns (me, my, your)	
Interrupts activity when you call his/her name		Understands use of objects	
Anticipates what will happen next		Understand part/whole relationships	
Actively searches for source of sound that is out of sight		Understands simple descriptive concepts (big, wet, little)	
Looks at objects or people the caregiver calls attention to		Follows two-step directions without cues	
Understands what “come with me” means		Understands quantity concepts (one, some, rest, all)	
Responds to “no-no”		Understands the pronouns his and hers	
Understands a specific word or phrase other than “no”		Understands negative sentences (which one is not?)	
Uses more than one object/toy during play			
Follows routine, familiar directions with cues			

CONTINUED: **ONLY COMPLETE THE FOLLOWING FORM IF YOUR CHILD IS 5 YEARS OLD OR YOUNGER**

MY CHILD IS ABLE TO:	YES OR NO	MY CHILD IS ABLE TO:	YES OR NO
Has a suck/swallow reflex		Uses five to ten words	
Vocalizes soft, throaty sounds		Uses vocalizations and gestures to request toys or food	
Responds to someone talking by smiling		Produces different types of consonant-vowel combinations	
Varies pitch, length, and volume of cries		Babbles syllable strings W/ inflection like adult speech	
Vocalizes pleasures and displeasure sounds		Names objects in photograph	
Vocalizes when talked to, moving arms and legs w/ sound		Uses words more often than gestures to communicate	
Protest by gesturing of vocalizing		Asks question	
Vocalizes two different vowel sounds		Uses words for a variety of pragmatic functions	
Vocalizes two different consonant sounds		Uses different word combinations	
Combines sounds to form a syllable		Uses plural “s” to describe more than one	
Seeks attention from others		Combines three or four words in spontaneous speech	
Plays simple games		Answers what and where questions	
Uses gestures to communicate (pointing, pushing, pulling)		Uses verb + ing to describe actions	
Able to vocalize without arm and leg movements		Uses a variety of nouns, verbs, modifies, and pronouns	
Participates in play routine w/ another person for 1-2 mins		Produces basic four- to five- word sentences	
Babbles two syllables together (mama, dada)		Names a variety of pictured objects	
Has a vocabulary of at least one word		Tells how and object is used	
Initiates turn-taking game or social routine		Uses quantity concepts (some, more, all, the rest)	
Extends a toy or points to an object to show others		Uses possessives (This is the “cat’s” bowl)	
Produces a variety of consonant sounds			
Imitates words			