The Speech Path
Your PATH to success starts here.

Occupational Therapy
Physical Therapy
Speech Therapy

Patient Handbook

Patient Handbook
The Speech Path, LLC
Revision 3, 09/10/2010

225 Wes Park Dr. • Perry, GA 31069 • Phone: (478) 987-1610 • Fax: (973) 965-4580

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Welcome to The Speech Path!

We are dedicated to providing quality speech, physical, and occupational therapy services to you. Our services cover the continuum of care from pediatrics to geriatrics in order to meet all of your needs. Our mission is to provide physical therapy, occupational therapy, and speech language pathology services of the highest possible quality, while at the same time, delivering these services in a humanistic and ethical manner to any individual or agency in need of our services.

The entire staff of The Speech Path seeks to uphold the following values:

1. We value treating our patients and each other with the same courtesy, dignity, respect and professionalism we want for ourselves.
2. We value the thoughts and opinions of our patients and employees. We will respectfully listen to their input on how to continually improve our goals/policies and/or procedures. We encourage interaction, discussions and the exchange of ideas to improve our services.
3. We value providing the most effective and efficient treatment plan for our patients by combining the therapeutic process with education to enhance development. We believe it is important to include the patient, family, physicians, and teachers in developing a treatment plan to ensure optimal outcome. The needs of the individual will determine the plan and duration of treatment.
4. We value providing the highest quality service at the lowest possible cost, with the best utilization of our resources.
5. We value integrity and strive to maintain honesty and good ethics in all relationships.
6. We value and respect the uniqueness and dignity of all individuals.
7. We value having a positive, cooperative relationship with our community medical staff and schools to provide a safe and consistent continuum of care.
8. We value creating a caring environment in which to respond to our patients with the utmost compassion.

The key to success is your great understanding the business and treatment aspects of therapy. This new patient handbook contains very important information about our services, about financial obligations, insurance company guidelines, and regulations, and advocacy. Read all of the information very carefully. Share it with family members. Ask any questions you may have about what you read and begin participating in the therapy process today!

Therapy is a cooperative effort between our staff and you. The teamwork between your family and our family will help to foster successful communication. Please know that we welcome the opportunity to listen to your feedback at any point during your care. Thank you for choosing The Speech Path! We are your PATH to better communication, mobility, and life skills!

- The Speech Path Team

Financial Responsibility

Part of the treatment process involves you being financially responsible. You are personally responsible for the cost of all therapy services provided to you by The Speech Path, LLC.

We have agreed to file insurance claims with a number of insurance companies that we are 'in-network' with. We are considered ancillary service providers and are not employed by any insurance company.

The benefit information, or payments, differ by insurance and even by plan within each insurance company. We file claims in a very timely fashion and we expect payment within 60 days. However, if your insurance company does not respond to a claim within 60 days, you are responsible for immediate payment of all of the billed services.

You are responsible for paying your co-payments AT OR BEFORE the time of service. You are obligated by law to pay your co-payment. Co-insurance payments are also due at the time of service.

Having insurance is not a guarantee of coverage. Some insurance companies do not cover specific speech, language, swallowing/feeding problems, mobility, and sensory problems. Please read and learn your benefit plan.

The Speech Path's process for filing insurance claims:

1. Will the evaluation be covered? When we verify your benefits prior to your first visit, this is not a guarantee of payment. This tells us and you whether payment is available for the evaluation under your chosen plan.

2. Will therapy be covered? Some insurance companies require authorization for therapy. This authorization is based off of the evaluating therapist's assignment of diagnosis, and whether this diagnosis is paid for under your insurance's fee schedule. The authorization process can be lengthy. We recommend that in the meantime you make private payments while we are waiting on the authorization. We also recommend that you become extremely involved in the process of authorization approval by calling your insurance company regularly to inquire about the status of the authorization. With regards to the insurance companies that do not require authorization, we can provide you with diagnosis codes and procedural codes that will be billed for therapy visits, and you can call your insurance company to find out if these codes are covered under your policy. Otherwise, we can bill your insurance company with the assumption that it is covered. If, however, any claim is not paid, you are responsible for the entire billed amount.

3. Authorization information: With regards to companies that require authorization for services, the authorization is usually for a set-amount of visits/units within a certain date-range. We can always request more visits/units for another date-range, but there is no guarantee that it will be granted. When your authorization is pending expiration, we try very

hard to request more therapy (if warranted) in a timely fashion so that services do not have to be halted. However, this is not always possible. During this period, we accept private payments so that therapy is not interrupted. If you choose not to come, we cannot guarantee that your slot will be held. Therefore, it is in your best interest to make private payments and continue to come so that your services do not lapse.

4. Please keep in mind that you are the policy holder. As such, it is within your rights to advocate for yourself/family for services covered. You have the right to file appeals, to request that services be covered (even if they are not typically covered by that plan), etc. You are paying for the insurance so that they can pay for your medical services. Please do not hesitate to become involved on behalf of your family to promote the best care for your family.

If we are not a provider for your policy, we can attempt to find out if the evaluation and or therapy can be covered out of network. As a courtesy, we can also file paper claims to your insurance company. If we do not hear back from them within 60 days, you will be responsible for the billed amount. In addition, you will be responsible for any amount that is denied by an out of network insurance. If you have an insurance that is out of network, we highly recommend that you contact our director of financial services to find out your options.

If you need to self-pay, you may work with the billing department to schedule a payment arrangement. You can reach the billing department by calling 478-987-1610.

Payments and Charges

In order to uphold services at The Speech Path, your financial responsibilities must be met. In order to accommodate that, we offer several flexible payment options.

Payment is always due at the time of service with no exceptions. We accept cash, checks, and credit cards (Visa, Discover, and Master Card). Many of our patients keep a credit card number on file with us that states withdrawal schedules that meet their needs. If you cannot pay your entire balance at the time of service, you will not be allowed treatment until your balance is paid. Your slot will not be held, but you may call back in to be placed on the schedule once your balance is paid in full.

Our return check fee is $50. This must be paid prior to your next therapy session.

If we collect money from the insurance company after you have made a payment, the money will be credited to your account or refunded to you if you are no longer a patient.

There are times when your therapist may recommend certain therapeutic devices that may help with lasting progress. These items can be bought, at cost, from The Speech Path. It is okay if you wish to purchase the items yourself. We will not bill your insurance company for these devices.

We send out monthly invoices to our patients that owe a balance. This statement should reflect charges to your insurance company, payments received from you and your insurance company, and the remainder owed. If a balance happens to accrue outside of you paying at the time of service, balances are due upon receipt of the invoice.

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Attendance

In order to ensure success, regular attendance is needed as well as completing any home program outlined by the treating therapist. A designated time has been scheduled for you with reoccuring appointments weekly (or as outlined by your therapist). Activities and educational materials have been planned for you as well as a portion of time from the treating therapist. The Speech Path EXPECTS that you will uphold an attendance of at least 75%. If your attendance falls below 75%, however, you will be notified. If it continues to fall, and falls below 70%, we hold the option to discharge you from our services. Your physician will be notified of your attendance history via a letter.

Typical 30-minute treatment sessions will consist of 25-minutes of direct therapist/patient interaction. The remaining 5-minutes will be utilized for completion of paperwork, as well as caregiver education. We strongly encourage you to arrive on-time for all therapy sessions in order to ensure the best use of your appointment time. Your success is important to us and is greatly dependent upon your commitment to consistent attendance and on-time arrivals.

Cancellations

The Speech Path requests that if you have to cancel your therapy session, you make cancellations as soon as possible. This allows us time to give your designated appointment time to someone who as been waiting on an appointment or someone who needs to make-up an appointment. The Speech Path requires all cancellations to be made by 9:00 a.m. on the day of evaluation/therapy or be charged a late cancellation fee of $40.00. These cancellation fees are due prior to your next regularly scheduled session. Insurance companies will not be charged for the missed or cancelled appointment. Appointments may be rescheduled at the time of cancellation and must be completed within five (5) business days to avoid being charged a cancellation fee.

No Shows

If you miss an appointment without contacting the The Speech Path office, you will be charged a No Show fee of $50.00. You may avoid a No Show fee by rescheduling your appointment within two (2) business days of the missed appointment. If you accrue 2 no shows in a row, you will be discharged from our services and your physician will be notified via a letter of your poor attendance. Insurance companies will not be charged for the missed appointment.

Illness and Accidents

Unforeseen illnesses and accidents happen when least expected leaving no choice but to cancel therapy on short notice. If you or your child is sick or become injured, you may provide a physician's note substantiating the illness/injury and you will not be charged. The patient should not attend therapy if fever, diarrhea, or vomiting has occurred in the past 24 hours. We will be more than happy to reschedule your appointment when you recover. Should your therapist become ill, or go on vacation, etc., you will be scheduled at your regular time with another therapist or notified and rescheduled when there is an available time slot. Please contact the Company Administrator with any concerns.

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Expediting Your Insurance Benefit Coverage

The most important thing you do to maximize your insurance benefit potential is to become active in coordinating your insurance plan benefits. We will be happy to assist you in outlining or providing additional information to help educate you with regards to maximizing your therapy coverage. Please let us know if you would like an educational packet.

Please keep us informed. You are the responsible party that ensures physical, speech, and occupational therapy coverage from your insurance company. We are here to assist in any way we can.

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Rights and Responsibilities

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Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

1. Request a restriction on certain uses and disclosures of your health information by delivering the request to our office -- we are not required to grant the request, but we will comply with any request granted;

2. Appeal/denial of access to your protected health information, except in certain circumstances;

3. Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:

    a. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    b. Is not part of the health information kept by or for the office;
    c. Is not part of the information that you would be permitted to inspect and copy; or,
    d. Is accurate and complete.

4. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

5. Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;

6. Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

7. Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please our Company Administrator (478-987-1610) in person or in writing, during regular, business hours. She will inform you of the steps that need to be taken to exercise your rights.

Notice of Privacy Practices for Protected Health Information

Effective Date: January 1, 2010

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

1. A therapist obtains treatment information about you and records it in a health record.

2. During the course of your treatment, the therapist determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:

1. We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

1. We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Our Responsibilities

The office is required to:

1. Maintain the privacy of your health information as required by law;
2. Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
3. Abide by the terms of this Notice;
4. Notify you if we cannot accommodate a requested restriction or request; and,
5. Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Company Administrator.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Company Administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address is: Office for Civil Rights - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F, HHH Building - Washington, D.C. 20201.

1. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
2. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care, if you do not object, or in an emergency.

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

We may use and disclose your protected health information to assist in disaster relief efforts. Workers Compensation If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a

work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses

Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under “Your Health Information Rights.”

Website

If we maintain a website that provides information about our entity, this Notice will be on the website.

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I have read and understand this privacy policy.

_____
Signature of Patient or Patient Representative

_____
Date

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Authorization to Bill Credit Card for Services

I _____, authorize The Speech Path to bill my credit card for therapy services rendered, late cancellations, and/or no-show fees. I understand that I have the right to cancel this automatic payment option at any time. This form is valid for one year and a written request to cancel must be provided to The Speech Path before the 12 month term. The recurrent billing will automatically terminate upon the discharge of services if no balance remains.

I authorize The Speech Path to keep my signature on file and to charge my account for the balance of charges not paid by insurance within 60 days and not to exceed $_____. My credit card information is as follows:

_____
Name on Card

Type of Credit Card (please circle): VISA MASTERCARD DISCOVER

_____/_____/_____
Credit Card # Exp. Date 3 digit CCV#

Billing Address:

_____

Please check the the debits that you authorize:
_____ Co-payments
_____ Deductibles
_____ No show
_____ Late cancellations charges
_____ All visits from _____ to _____
_____ Recurring charges of $ _____

Circle one: Monthly Weekly

Special Instructions: _____

_____
Signature

_____
Date

_____
Patients Name

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Website/Video Release Form

I hereby authorize The Speech Path, LLC to use:

_____ My Picture
_____ My Video Image including Speech

My image may be used for:
_____ Reports sent to insurance companies, referring physicians and families
_____ Advertising purposes
_____Website

Limitations:
_____ None
_____ Other (Please List)

_____
Patient/Guardian Signature

_____
Date

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Release of Information

I, _____ (Please Print Name), authorize The Speech Path, LLC to release and obtain clinical information regarding:

_____(Patient's Name),

_____ Medical Information – Diagnosis, Onset, Treatment Regimen

_____ School Documentation/IEP/FIE/Attendance

_____ Physician notes related to Speech/Language/Hearing/Cognition

_____ Psychiatric Evaluation/Treatment Information

_____ Physician notes related to fine motor, mobility, sensory awareness, and ADL's

_____ Other_____

To and from the following persons or agencies:

_____

Name Address Phone Number

_____

Name Address Phone Number

_____

Name Address Phone Number

In consideration of treatment and educational purposes, I give consent that sound recordings, records, and/or photographs may be used as deemed helpful by the staff.

This form has been fully explained to me/us and I/we understand the contents.

_____

Name Date Relationship to the Client

_____

Witness Date Position

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Patient Financial Responsibility

Payment is required at time of service. *You are responsible* for the full balance due if your insurance does not provide coverage for therapy or fails to pay the amount in full (within 90 days). You will be expected to pay your full balance before you receive additional services. If you are unable to pay your balance in full at the time of service, you will be turned away for services until your balance is paid in full. We cannot guarantee that a slot will be held for you while we are waiting on your payment. However, you can always call back to be placed on the schedule once your balance is paid in full.

Verification of benefits is not a guarantee of payment. You are responsible for any charges not covered by your insurance. Benefits are subject to eligibility at the time of service. All specific plan provisions, exclusions and limitations will be applied at the time the claim is processed.

I understand **I am responsible** and will pay for all the following charges before my child or I attend the next therapy session:

CO-PAYMENTS/DEDUCTIBLE/CO-INSURANCE – due at time of service
LATE CANCELLATION (past 9:00 a.m. on day of service) without rescheduling - $40
RETURNED CHECKS - $50/check
NO SHOW CHARGES - $50
OTHER FEES due after insurance processes - due upon receipt of invoice.

Please indicate your preference and sign below. (Check one only)
_____ I agree to self-pay The Speech Path for all services.

_____ The Speech Path should bill my insurance carrier and I will pay for co-payment, co-insurance, deductible and any other payment that my insurance does not cover that is related to billed amounts by The Speech Path.

_____ I will pay The Speech Path for services rendered and The Speech Path will provide me the information to bill my insurance carrier to attempt recoupment of funds.

I am fully aware that I am to pay my balance in full before the time of service and that if I cannot pay, I will be turned away for services until my balance is paid. I understand that I will be charged a late cancellation fee for cancelling past 9:00 on the day of service and I will be charged a no-show fee for not showing up for a scheduled appointment. I understand that I will be discharged from services for 2 no-shows and attendance that falls below 70%.

I, the undersigned, understand the above conditions to be a legally binding agreement.

_____ _____

Patient or Patent Representative Office Staff

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Rescheduling Missed Appointments

You may make up your missed appointment (cancellation/no show) within five (5) business days to avoid charges (The appointment must be made up before your next regularly scheduled appointment). We will make every effort to reschedule with the patient's treating therapist. However, if this is not possible, we will schedule the patient with another therapist that will be familiar with the patient's treatment/therapy goals. The make-up therapist will communicate session results with the regular treating therapist to ensure continuity of care.

I have read the attendance policies of The Speech Path. I will make every effort to arrive on time for all appointments. I understand that my attendance must remain at or above 75%. If I have to cancel my appointment, I will make every effort to reschedule my appointment. If I no-show, I will make every effort to reschedule the appointment. I understand there is a charge of $40 for late cancellations and a charge of $50 for no-shows.

_____
Signature of Patient or Guardian

_____
Patient Name

_____
Date

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