Chatterbox
Speech Therapy Llc

702 East Ohio Street, Suite 1
Clinton, MO 64735
816-835-8910
www.chatterbspeech.com

Patient Registration Form

Patient Information

Date Completed: _____

Patient Name: _____
Last First MI

Sex: _____ DOB: ____/____/_____
M/F Month Day Year

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

How did you hear about us? Doctor _____ Website _____
Friend _____ Other _____

Referring Physician: _____ Referring Physician Phone: _____

Primary Care Physician: _____ Primary Care Physician Phone: _____

Primary Dentist: _____ Primary Dentist Phone: _____

Precautions/Allergies

List Food Allergies: _____

Latex Allergy: Yes or No Has Seizures: Yes or No

List all other allergies: _____

Responsible Party (Parent/Legal Guardian)

Name 1: _____
Last First MI

Relation to Patient: _____ DOB: ____/____/_____
Month Day Year

Address: _____

(continued)

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Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Name 2: _____
Last First MI

Relation to Patient: _____ DOB: ____/____/_____
Month Day Year

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Name 3: _____
Last First MI

Relation to Patient: _____ DOB: ____/____/_____
Month Day Year

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

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Insurance/Payer Information

Name (as it appears on the policy): _____

DOB: ____/____/_____ Sex: M/F
Month Day Year

Contact (If child): _____ Phone: _____

Primary Insurance

Co-Pay : $_____ Deductible: $_____

Insured/Policyholder's Name: _____

Insured's Address: _____
(If different than the patient)

DOB (policyholder): DOB: ____/____/_____ Relationship to patient: _____
Month Day Year

Insurance Company: _____ Date Coverage Began: _____

Member ID Number: _____ Group Number: _____

Employer: _____

Secondary Insurance

Insured/Policyholder's Name: _____

Insured's Address: _____
(If different than the patient)

DOB (policyholder): DOB: ____/____/_____ Relationship to patient: _____
Month Day Year

Insurance Company: _____ Date Coverage Began: _____

Member ID Number: _____ Group Number: _____

Employer: _____

(continued)

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Assignment of Benefits

I hereby authorize payment by my insurance carrier of the benefits, otherwise payable to me, to be made directly to Chatterbox Speech Therapy, LLC for their services.

I authorize Chatterbox Speech Therapy, LLC, to release to all insurance companies and/or compensation carries only such diagnostic, therapeutic, and financial information as may be necessary to determine benefits entitled and to process payment claims for health services that were provided.

The insurance information collection is an attempt to collect a debt. Any information obtained will be used for that purpose.

I understand and agree that I am financially responsible for charges not covered by assignment.

_____ _____

Signature of Responsible Party or Patient Date

Office Use Only

CPT: 1) _____ 2) _____

ICD-9: 1) _____ 2) _____

☐ Missouri ☐ Kansas ☐ Referred: _____

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Financial Policy

Chatterbox Speech Therapy, LLC is a participating provider with most major health insurance plans. As a courtesy, we are happy to submit claims related to therapy charges on your behalf. In accordance, we will perform an initial verification of benefits and determination of exclusions under your existing policy and apprise you of the results.

It is important to understand all of the specific language of your individual health insurance plans so families are encouraged to do their own investigation on benefits and coverable services. It is also important to note that a verification of benefits does not equal a guarantee of payment.

Individual health insurance plans have different methods of determining whether this might be a 'covered service'. That includes a determination of 'medical necessity'. Families are encouraged to provide a written referral from their medical physician at the time of initial service. Chatterbox Speech Therapy, LLC, under the contractual agreement, cannot waive deductibles, copays, or coinsurance responsibilities.

Fees, policies, and coverage are a contract between families, employers, and their individual health plans. Chatterbox Speech Therapy, LLC, is not in any way responsible for any changes to plan language or charges associated with your particular plan.

Chatterbox Speech Therapy, LLC, requires payment (private, copay, coinsurance, deductible) in full from the patient's responsible party at each time of service. We are happy to offer itemized receipts for HRA, Medical Flex Plans, Health Savings Accounts or invoice itemizations in cases of divorce as requested. Invoices will be submitted to you electronically within 3-4 working days of your initial request. We WILL NOT separately invoice divorced parents for 'their share' of estimated payments.

Families with a balance of $300 or more on account will have all services discontinued until that account is paid in full.

(continued)

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If you are in the process of appealing your insurance company's decision regarding coverage, it is expected that you take on the responsibility of paying for services until the appeal process is complete. In the event that you win an appeal, we will happily reimburse you upon receipt of payment from your insurance company for any overpaid amounts.

Most major health insurance plans reserve the right to review claims up to 3 years AFTER a specified service date, and also reserve the right to demand repayment of funds for a procedure that might not be seen as coverable. Chatterbox Speech Therapy, LLC, therefore, reserves the right to demand payment in full from the families who have already obtained services. Chatterbox Speech Therapy, LLC, will not accept the financial liability for services requested that are subsequently denied by a health insurance carrier. Responsible party understands they are fully financially liable for any services denied, or requested reimbursement of services, that might previously been paid and subsequently denied by the health plan.

Families (for billing convenience) may be requested to leave a credit card on file for billing purposes alone. Receipts for services will be provided accordingly.

I have read and agree to the financial policies above.

_____ _____

Signature Date

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Payment Contract

Patient Name: _____
Last First MI

Responsible Party (if child): _____
Last First MI

Relationship: self _____ parent _____ other (specify) _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Please initial which type of payment option you prefer:

_____ I hereby acknowledge and agree to pay treatment fee balances at the time of service.

_____ I hereby authorize Chatterbox Speech Therapy, LLC, to use AutoPay one time weekly in order to keep my/my child's account balance current with the credit card information below.

_____ I understand that I have the right to cancel my AutoPay with written notification to Chatterbox Speech Therapy, LLC, and 10 days notice prior to cancellation of card.

Card Information: (Visa and Mastercard only)

Mastercard _____ Visa _____ Credit _____ Debit _____ HRA/HSA _____

Card Holder Name: _____

Card Number: _____

Expiration Date: _____

Secure Code: _____

I understand this information is kept private and confidential and is protected by HIPPA regulations under patient confidentiality.

_____ _____
Signature Date

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HIPPA

(Health Information Privacy and Portability Act)

Your Rights and Responsibilities

- You are entitled to get an electronic or paper copy of your medical record within 30 days of your request
- You may ask us to correct your medical record. We reserve the right to refuse your request and will notify you in writing within 60 days of your request
- You have the right to request confidential communications in regards to how information is supplied to you: phone, email, fax, etc.
- You may request that we NOT use or share certain health information related to treatment, payment or operations. You may request that we not submit your claims to an insurance plan for purpose of payment if you opt to pay in full
- You may request an accounting of the number of times we have shared your information up to but not beyond a 6 year period
- You may request a copy of this privacy notice
- You may choose someone other than yourself to act in your place provided authorization paperwork is in place
- You may file a complaint if you feel your personal privacy rights have been violated by contacting us in writing

Your Choices:

- You have the right and choice to request that we share your information with family, close friends, or others involved in your care
- We will never share your information with anyone without your specific written permission

Our Uses and Disclosures:

- We may share your health information with other professionals involved in your treatment
- We may use your information to run our practice, improve your care and contact you when necessary
- We can share your health information to bill and receive payment from health plans or other entities
- We can share health information you for certain situations involving public health and safety issues
- We may share your information for the purpose of investigative research
- We may share your information to be compliant with federal and state law
- We may share your health information to address issues related to law enforcement; worker's compensation and other government requests or in cases of litigation

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if any breach occurs that may have compromised your protected health information
- We must follow the duties and privacy practices described in this notice and give you a copy of it (as requested)
- We will not share or use your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.

_____ _____

Signature Date

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Office Policies

Please be advised of the following office information:

1. Payment: Payment is due weekly. Insurance deductibles, private pay, coinsurance and copays are due at the time of service. Payment is accepted in cash, check or credit card. HRA and Health Savings Account cards are welcome. Receipts are available at the time of payment or via email (if requested in writing).

   _____ Initial

2. Scheduling: Scheduling is done in advance with input from families. Due to demand it is not possible to constantly rearrange schedules from week to week for other social or extracurricular activities once a specific time slot is provided. If there is a serious issue, please notify your therapist and we will try to honor your request. Remember: by committing to a weekly appointment, another individual cannot fill that time slot; it has been "reserved" for you. If you want to hold a weekly slot you must be committed to that time and day. Summer scheduling is always different.

   _____ Initial

3. Vacations and Holidays: Chatterbox Speech Therapy, LLC, is closed for most major holidays. Please contact your therapist for details. All families and all therapists take individual vacations and holidays. Please notify your therapist of vacation plans with at least 7 days notice so schedule changes can be accommodated.

   _____ Initial

4. Cancelations:

   Non Emergency: 24 hours notice: This includes vacations, pre-planned doctor's appointments, family events, parties, sports events, lack of baby sitter, etc. This includes anything that is not designated by "emergency" (see below). The session must be canceled within 24- hour notice. If cancellations become excessive for nonemergency purposes, then the client may lose his/her weekly slot in the therapy schedule. If the session is not canceled within 24- hour notice a last fee of $30 per session will be billed. Individuals who do not call or show up for an appointment will receive written notification and incur a $55 charge payable prior to the next scheduled session.

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Emergency: Cancel by 9:00 AM: Emergency cancellations are due to illness, death in the family, or illness of a family member. These sessions must be canceled by 9:00 AM on the day of the therapy slot. If your child does not go to school, you should call first thing in the morning to report the illness. It is understood that on some occasions children are sent home late in the day. If this happens on occasion beyond the family's control, you will not be billed.

Please do not bring your child with a fever, strep throat, unidentified rash, diarrhea, vomiting or any highly contagious illness. In general if they are too sick for school they are too sick for therapy. Your child must be fever free for 24 hours. If your child appears ill you will be billed for that session, and sent home from therapy.

Inclement Weather: Cancel by 9:00 AM: When a storm is expected, or the roads are dangerous, the office usually closes. It is understood that some clients may live far away, and while the office may not be closed, you may choose to stay home with your child. In this case you must follow the procedure for EMERGENCY cancellations, and call by 9:00 AM that day if you think you would prefer not to travel, or you will be billed. Periodic storms may result in office closings. Please call if you are unsure.

Overall Attendance: Regular attendance at the designated appointment time is expected. Progress depends upon consistent attendance. If insurance is paying for the service, they also require you attend a regular attendance pattern to show progress. Therefore, if a client has less than 80% attendance rate per month, (unless previously arranged with the office) specific appointment times may be forfeited and therapy will be terminated.

_____ Initial

5. Waiting Room/Bathroom: The waiting room is a place for families to relax and socialize before, during and sometimes after an appointment. Please refrain from eating/drinking, excessive conversations on your cell phone and loud play with your children in the waiting area. The bathroom is for all patients. Please be considerate of others. Do not flush sanitary products in the toilet, and dispose of all soiled diapers in the outside dumpster. In addition, please do not enter the therapist's private office.

_____ Initial

6. Lateness: All therapists run on a schedule. When families arrive late, it naturally takes time from the person whose appointment immediately follows. As such, individuals who are 5-10

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minutes late for appointments will only be seen for the balance of their appointment time. As appointments run directly on the half hour please be on time for your session to assist in maximum progress gains. Also, making payments related to deductibles, copays, and coinsurance PRIOR to each session will allow for smooth office flow.

_____ Initial

7. Observations and Homework: THE OFFICE IS NOT A DROP OFF FACILITY. A PARENT OR CAREGIVER MUST BE IN THE OFFICE AT THE TIME OF THERAPY. Daily carryover is essential to your child's progress. It is therefore critical that parents and caregivers observe therapy sessions, and make every effort to work with the child at home. Activities learned in a session should be practiced 3-4x weekly for 10-15 minutes. If carryover is not performed, the office cannot be held responsible for progress levels, or lack thereof. Caregivers are welcome to attend sessions if they will be doing the speech homework. Other therapists who work with the child will need to set up an appointment to attend a session for observation and will be required to sign a "confidentiality disclaimer" at the time they attend. Last minute drop-ins will not be accepted.

   _____ Initial

8. Discontinuation of Services: If you plan on discontinuing services for any reason, you must give this office 2 weeks noticed or you will be billed for the missed sessions. A discharge report will be prepared free of charge if you have been up to date with payments, and give this office ample notice.

Signed: _____

Date: _____

Name of Patient(s): _____