REDMOND
SPEECH & LANGUAGE
SERVING ALL OF CENTRAL OREGON

CLIENT INFORMATION

MR#_____

Child's Full Name: _____ **DOB:** _____ **Gender:** _____

Name of Person completing this form: _____ Relationship to child: _____

Mother/Guardian's Name: _____ DOB: _____

Address: _____

Phone (circle: home/work/cell): _____ Occupation: _____ Employer: _____

Father/Guardian's Name: _____ DOB: _____

Address: _____

Phone (circle: home/work/cell): _____ Occupation: _____ Employer: _____

Living Situation: (circle one) Married Single Divorced/Separated Other

Siblings: _____ Age: _____ Grade: _____

_____ Age: _____ Grade: _____

_____ Age: _____ Grade: _____

Preferred Email Address: _____

Preference for Auto Reminders (circle one): email phone call text message

ANY ADDITIONAL COMMENTS (Please continue on back if extra space is needed):

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NOTICE OF FINANCIAL RESPONSIBLITY

- **I hereby give Redmond Speech & Language: Total Communication Services, LLC authorization to file claims for services rendered on my behalf. Any claims that are not paid or authorized by the insurance carrier will be my responsibility.**
  _NA__ *initials*
- **I authorize payment of medical benefits to Redmond Speech & Language, LLC for all services.**
  _NA__ *initials*
- **I authorize the release of any medical or other information necessary to process all claims. I also request payment of government benefits to Redmond Speech & Language, LLC.**
  _NA__ *initials*
- **If payment is not issued by the insurance company within 90 days of initial filing, you are responsible for following up with insurance company and for payment of services.** _NA__ *initials*
- **For patients paying privately or with set co-payments, these are due at the time of service. Coinsurance (base on percentage) and deductible amounts due when EOB statements are received.** _____ *initials*
- **If your portion of payment is not made within 60 days, your child's appointments will be placed on "Hold" until the balance due is paid in full.** (See our policy for cancelations/missed appointments) _NA__ *initials*
- **Clients with deductibles must pay the contracted rates that Redmond Speech & Language has with your insurance company.** It is illegal for us to offer a reduced or discounted rate when you have a set deductible / coinsurance. _NA__ *initials*
- **For clients receiving speech/language therapy services there maybe multiple codes billed. Based on therapy modalities provided there maybe fluctuating charges.** _NA__ *initials*
- **All Returned Checks will incur a $30 service fee.** _____ *initial*
- It is your responsibility to inform the office as soon as possible if there is an insurance change and provide the office with the new insurance card. ***Failure to do this as soon as possible may result in the inability for us to obtain authorization for treatment, resulting in charges to your account at a regular rate.** _NA__ *initials*
- Please inform the office of any foreseen cancellations within 24 hours of your appointment time. **All No-Show or Short Notice (less than 24 hour notice) appointments will incur a $30 fee/30 minute session or a $50 fee/50 minute session.** *Please note that insurance companies do not reimburse for these charges and they will be your responsibility. Three "no show" cancellations or habitual cancellations will result in the loss of a reserved treatment time slot and/or being discharged from therapy. _____ *initials*

FINANCIAL RESPONSIBILITY

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred by my child. The undersigned certifies that he/she has been provided the evaluation and treatment costs and is the responsible party and accepts these terms.

_____ _____
Responsible Party Signature Date

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CONSENT AND ACKNOWLEDGEMENT

Consent for Care and Treatment: As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's speech language pathologist as is necessary in their judgment. I understand that my child is under the care and supervision of a speech language pathologist. I authorize release of medical information to the Redmond Speech & Language team for continuity of care.

_____ _____
Signature of Legal Representative of Child Date

Acknowledgement of Notice of Privacy Practices: I acknowledge that Redmond Speech & Language: Total Communication Services, LLC will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. Our Notice of Privacy Practices provides further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law.

_____ _____
Signature of Legal Representative of Child Date

PHOTOGRAPH AND VIDEO RELEASE FORM

I authorize Redmond Speech & Language: Total Communication Services, LLC to photograph my child for use in the following categories. Parents or other clients may ask the names of the children in the pictures. I authorize that my child's first name may be mentioned when referring to these pictures.

I Give Redmond Speech & Language Permission to:	**Yes**	**No**
Take photographs or video for therapeutic purposes	_____	_____
Use photos for publicity purposes	_____	_____

_____ _____
Signature of Legal Representative of Child Date

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Authorization for Release and Disclosure Of Protected Health Information

In accordance with state and regulatory agency requirements, the medical record is the property of Redmond Speech & Language: Total Communication Services, LLC

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

I hereby authorize that my medical information be released to:
ALL MEDICAL SERVICES OR:

_____
_____

FROM:
Redmond Speech & Language: Total Communication Services, LLC
326 SW 7th St, Redmond OR 97756

Please release the following information:

___Initial Evaluation ___Re-evaluation ___Progress Notes ___Plan of Care

___History and Physical ___Discharge Summary ___Psychological Evaluation

___Other (Specify) _____

This information is necessary for the following purpose:

___ Continued Patient Care ___Insurance ___Other (specify) _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to Redmond Speech & Language. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, this authorization will continue until therapy is terminated.

4. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

This information has been disclosed to you from records protected by federal law (42 USCA Sec. 290-dd (2). Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 USCA Sec. 290-dd(2).