REDMOND
SPEECH & LANGUAGE
SERVING ALL OF CENTRAL OREGON

Dear New Patient,

Welcome to Redmond Speech & Language, where we provide total communication services.

At Redmond Speech & Language, our goal is to provide a wide range of evidence-based speech and language services to our community. We seek to collaborate with families and other professionals to effectively meet each patient's needs. We believe in each individual's right to communicate.

Our therapy staff are consummate professionals who are committed to mutually held values of integrity, service, professionalism, and research-based evaluation/treatment.

This New Patient Packet contains important information and forms necessary to complete prior to evaluation and treatment. Please take time to read all of the information carefully and feel free to ask any questions as you go through this process.

Communication therapy is a cooperative effort between our staff and you. Together we can make a difference in your communication or that of your family member.

Thank you for choosing Redmond Speech & Language: Total Communication Services, LLC.

Sincerely,

Angela Bacuyani, MA CCC-SLP Christina Stevenson, M.S. CCC-SLP

Angela Bacuyani, M.A. CCC-SLP & Christina Stevenson, M.S. CCC-SLP
Owners
Redmond Speech & Language: Total Communication Services, LLC

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GENERAL GUIDELINES

The following information is a list of general guidelines that will assist in creating a treatment environment that is as efficient and smooth as possible. If you have any questions, please speak with your therapist.

1. Please have your child dressed in clothing that is easy to move in and is OK if it gets dirty.

2. Individual treatment sessions are generally 30 or 50 minutes. The last 5-10 minutes of the treatment session may be used for family education, discussion, and documentation. If you feel that you need additional time to discuss issues, please schedule that time with your therapist. This will prevent running into the next appointment. If you leave the clinic during your child's therapy time, please return 10 minutes prior to the end of the session to allow ample time for therapists to discuss the session and complete documentation.

3. You will be notified as far in advance as possible when your therapist is ill or otherwise unable to attend. Every effort will be made to shift to teletherapy, reschedule, or provide a substitute therapist for your appointments so that your child will miss as little treatment as possible.

4. A patient may be sent home or shifted to teletherapy if they:
   - Appears ill and is unable to participate in therapy.
   - Is suspected of having a contagious disease/condition.
   - Sustains an injury which needs medical attention or close observation.
   - Has active head lice.
   - Exhibits vomiting and diarrhea.
   - Has a fever of 100 degrees or greater (a patient may not return to Redmond Speech & Language until they are fever free for 72 hours off of fever reducing medication such as Tylenol or Motrin).

5. Please leave information on how to contact you if you do not stay on the premises during the treatment session in case of any emergencies. Therapist will walk minors out of the building to meet their family. We do not have the means for childcare. Failure to return in a timely manner more than one time will result in a requirement that you do not leave the premises during your child's treatment.

6. To increase consistency and progress in the therapeutic setting, we have a text reminder system in place to remind families of their appointments and help our therapists plan for their sessions each day. You will receive several reminders between 72 hours and 2 hours prior to your appointment. Additional reminders can be added to accommodate multiple family members if needed. Please respond to each reminder as soon as possible. Contact your therapist or the front office directly for any rescheduling needs.

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HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by Redmond Speech & Language: Total Communication Services, LLC. and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your health care bills, to support the operation of the Redmond Speech & Language's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of speech pathology students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

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PATIENT INFORMATION

Child's Full Name: _____ **DOB:** _____**Sex:** Male_____ Female_____ Other_____

Gender ID (write): _____ **Preferred Pronouns (write):** _____

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

Mother/Guardian's Name: _____ DOB: _____

Address: _____

Phone No.: _____ Phone Type: _____ Is **mother** the policy holder for insurance plan? Yes No

Occupation: _____ Employer: _____

Preferred Email Address: _____

Father/Guardian's Name: _____ DOB: _____

Address: _____

Phone No.: _____ Phone Type: _____ Is **father** the policy holder for insurance plan? Yes No

Occupation: _____ Employer: _____

Preferred Email Address: _____

Living Situation (are parents)**:** Married Single Divorced/Separated Other

Siblings: _____ Age: _____ Grade: _____

Siblings: _____ Age: _____ Grade: _____

Siblings: _____ Age: _____ Grade: _____

Are you/will you be working with Treehouse Therapies? • If yes, please name therapist:	Yes	No
Other Professional Providers: (specialists, occupational/physical/speech therapy, counseling, tutoring, etc): *please list name and contact number. Also please list previous therapies or services your child has received and the approximate dates they received them.*		

MEDICAL INFORMATION:

PRENATAL/BIRTH HISTORY		
1. Were there any complications/meds during pregnancy?	Yes	No
2. Was the pregnancy pre-term?	Yes	No
● What was the child's weight at birth?		
● Number of weeks gestation at delivery:		
3. Any abnormalities in labor/delivery?	Yes	No
4. Were there any complications after birth?	Yes	No
If you answered "yes" to questions 1-4, please explain: Any other comments (use additional sheets if needed):		

CHILD MEDICAL HISTORY		
5. History of major illnesses:	Yes	No
6. History of hospitalizations:	Yes	No
7. Are there any diagnosed mental, physical or emotional conditions/disabilities?	Yes	No
8. History of ear infections:	Yes	No
● If yes, how many:		
9. Date of last hearing exam?	Results:	
10. Date of last physical exam?	Results:	
If you answered "yes" to questions 5-8, please explain: Any other comments (use additional sheets if needed):		

SOCIAL/ EDUCATION HISTORY		
11. School/Day Care:	Grade:	
12. How is your child doing academically/pre-academically?		
13. Activities your child enjoys:		
14. Does your child prefer to do these activities alone or with other children/siblings?		
15. Does your child receive special services in school?	Yes	No
● Describe services listed on IEP/IFSP:		
Comments:		

DEVELOPMENTAL MILESTONES

16. Do you feel that your child met their developmental milestones on time when compared to peers or siblings?	Yes	No
17. Does your child appear to participate in age appropriate activities (i.e. social/play skills, motor skills, feeding, etc.)?	Yes	No
18. Age child used single words (e.g., no, mom, doggie, etc.)		
19. Age child combined words (e.g., me go, daddy shoe, etc.)		
20. Age child used simple questions (e.g., Where's doggie? etc.)		
21. Age child engaged in a conversation:		

COMMUNICATION SKILLS:

1. Current concerns/reason for referral:			
2. When was the concern first noticed? By whom?			
3. Has the concern/ problem changed since it was first noticed?			
4. Is your child aware of the concern?		Yes	No
● If yes, how do they feel about it (e.g. frustrated, embarrassed, etc.)? Explain:			
5. Did your child's speech or language development seem to stop?		Yes	No
● If so, when?			
6. What changes have been made to help your child's communication?			
7. How well do **you** understand your child's speech?	In context:____% of the time	Out of context:____% of the time	
8. How well do **others** understand your child's speech?	In context:____% of the time	Out of context:____% of the time	
9. How is your child at following directions?			
10. How is your child at carrying on a conversation?			
11. Has your child ever had speech therapy?		Yes	No
● When? Where? Results?			
12. My child communicates primarily via (e.g. gesturing, words, sentences):			
13. Does your child have difficulty understanding what others say?		Yes	No
14. Does your child have difficulty finding the words they want to say?		Yes	No
15. Does your child speak a language other than English? List:		Yes	No
16. Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, drooling, etc.)?		Yes	No
● If yes, please describe:			
17. Is your child sensitive to food texture/temperature, sounds, or touch?		Yes	No

- If yes, please describe:

18. Do other family members have any speech, motor, cognitive, or other disorders/delays?	Yes	No

- If yes, please describe:

19. What problems (other than speech) does your child have that concern you?

ANY ADDITIONAL COMMENTS (use additional sheets as needed):

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NOTICE OF FINANCIAL RESPONSIBILITY

FINANCIAL STATEMENTS	Initials
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.	
I authorize payment of medical benefits to Redmond Speech & Language, LLC for all services.	
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.	
If payment is not issued by the insurance company within 90 days of initial filing, I am responsible for following up with the insurance company and for payment of services.	
For each date of service, co-payments are due at the time of service.	
If my portion of payment is not made within 60 days, appointments will be placed on hold until the balance due is paid in full.	
The amount I owe is based on the contracted rates that Redmond Speech & Language has with my insurance company and cannot be negotiated.	
My appointment may include different types of speech/language therapy services and there may be multiple codes billed. Based on therapy modalities provided, there may be fluctuating charges.	
All returned checks will incur a $30 service fee.	
It is my responsibility to inform Redmond Speech & Language 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 Redmond Speech & Language to obtain authorization for treatment from my insurance company, resulting in charges to your account at a self-pay rate.**	

FINANCIAL RESPONSIBILITY

I have read the above and hereby accept all responsibility for the evaluation and treatment costs incurred. I certify that I am the responsible party and accept these terms.

_____ _____

Responsible Party Signature Date

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ATTENDANCE POLICY - updated 4/15/2022

Our mission is to provide evidence based speech and language services to every patient we treat. After research and based on years of experience, it is evident to us that patients make the best progress when seen consistently. Cancellations interrupt the progress of therapy and reduce the effectiveness of treatment. For this reason, families are expected to make every effort possible to attend scheduled appointments. The following outlines our cancellation/rescheduling procedures. Please initial each line.

_____**If I need to cancel I will call/text my therapist or the office ASAP.** Please give as much notice as possible if you need to cancel an appointment. We realize things happen last minute, but as soon as you are aware that you will need to miss an appointment, please notify us (even if after office hours).

_____**If I cancel more than 1 time per month, I must reschedule a make-up visit that takes place within the following two weeks OR pay a $50 cancellation fee*.** Regular attendance is necessary to make progress in therapy. When an appointment is rescheduled it is expected that I will attend that appointment in addition to my other scheduled appointments. Teletherapy is an option in most cases.

_____**If I cancel an appointment for any reason within 48 hours, I must reschedule a make-up visit that takes place within the following two weeks OR pay a $50 cancellation fee***. When canceled with less than 48 hours notice, we are unable to fill that spot with another patient on the standby list.

_____ **If I do not show up for my appointment without canceling ahead of time, I must reschedule a make-up visit that takes place within the following two weeks AND pay a $50 cancellation fee***. As you may have guessed, communication is important to us. Just send a quick call or text.

_____ **Failure to reschedule/pay the fee as directed above will result in the loss of my set appointment time.** Should that happen I will be placed on a standby list and my appointments will be scheduled with any open therapist

_____ **If I am on a standby schedule there is no guarantee that I will see the same therapist** each visit or that a time slot will be available that works for my schedule.

_____ **If I am gone for more than two consecutive weeks, Redmond Speech cannot hold my time slot or customary therapist**. If you are out of town, teletherapy is an option in most cases.

_____ I understand that **my insurance will not pay for cancellation fees,** and if a cancellation fee is owed it must be paid **prior** to my next appointment. Payment links can be found at redmondspeech.com

***MEDICAID PATIENTS:** By law, we are prevented from charging attendance fees to medicaid patients. If your insurance provider is medicaid, you do not have the $50 fee option. **Missed appointments must be rescheduled** and made up within two weeks. Failing this, you will be put on a standby list.

In signing this, I acknowledge that the above agreement and attendance policy was explained to me, and any questions regarding it have been answered. I also agree to follow the directions outlined in this policy.

Signature: _____

Patient Name: _____ 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. I have received a Notice of Privacy Practices which provides further detailed information about how my child's protected medical information is used and/or disclosed for treatment, payment, healthcare operations, and as otherwise allowed by law.

_____ _____

Signature of Legal Representative of Child Date

PHOTOGRAPH/VIDEO/VOICE RECORDING RELEASE FORM

I authorize Redmond Speech & Language: Total Communication Services, LLC to use videos/photos/voice recordings of my child for therapeutic purposes.

I Give Redmond Speech & Language Permission to:

Take photographs or video for therapeutic purposes Yes No

_____ _____

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:

Name of Person/Organization	Address	Phone/Fax/Email

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

Please release the following information: Initial Evaluation Re-evaluation Treatment Notes Discharge Summary

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. 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

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CREDIT CARD AUTHORIZATION

Redmond Speech & Language: Total Communication Services, LLC is requesting a credit card/debit card as a consistent form of payment, please fill out the section below. Thank you.

I authorize Redmond Speech & Language, LLC to keep my signature on file and to charge my account for balance of charges not paid by insurance within 60 days and not to exceed $_____.

Circle one: American Express Visa MasterCard Discover Card

____ This visit only

____ All visits this year

____ Co-payments

____ No show or late cancellations charges

____ All visits from _____ to _____

____ Recurring charges of $ _____

I understand this form is valid from the date that I sign until revoked in writing.

Client's Name _____

Cardholder's Signature _____

Card # _____

Expiration Date_____ CVC Code _____

Zip Code_____ Email Address (for receipt)_____