Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center

Client Contact Information

Client Name: _____ Today's Date: _____

Address: _____ DOB: _____

Email Address: _____ SEX: _____

State: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Referred by: (name and title): _____

Primary Care Physician: _____

Name of Practice: _____

Address: _____ Phone: _____

If client has a legal guardian, please complete the following:

Name: _____ Relationship to Client: _____

Address (if different from above): _____

Phone (if different from above): Home Phone: _____ Cell: _____

Work Phone: _____ Employer: _____

By initialing here, you authorize Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center to contact you via the email address provided above, regarding appointments and to send relevant medical information, including reports.

In case of emergency contact:

Name: _____ Phone: _____

Relationship to Client: _____

Insurance/Payment Information:

Person responsible for payment of services: _____

Insurance Company: _____

Primary Insured's Name: _____ DOB: _____

Insured's ID Number: _____ Insured's Group Number: _____

Relationship to client: _____ Primary Insured's Social Security #_____

Do you have a secondary insurance/Medicaid?

Insurance Company: _____ Policy/ID# _____

If my insurance policy/plan limits the number of therapy visits allowed, I understand that I am responsible for keeping track of the number of used or remaining visits. If the client is seen beyond the approved number of visits, I understand that I am responsible for all charges that exceed the allowed number of visits approved by my insurance company.

Initials: _____ Date: _____

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RELEASE OF INFORMATION AGREEMENT

Client Full Name: _____ Date of Birth: _____

I request and authorize Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center to release/exchange healthcare information of the client listed above to:

Name: _____

Phone: _____ Fax: _____

Business/Affiliation with Client: _____

Address: _____

City/State: _____ Zip: _____

This authorization applies to the following information (please be specific): _____

_____

This authorization expires on: _____

Name: _____

Phone: _____ Fax: _____

Business/Affiliation with Client: _____

Address: _____

City/State: _____ Zip: _____

This authorization applies to the following information (please be specific): _____

_____

This authorization expires on: _____

Name: _____

Phone: _____ Fax: _____

Business/Affiliation with Client: _____

Address: _____

City/State: _____ Zip: _____

This authorization applies to the following information (please be specific): _____

_____

This authorization expires on: _____

_____

Client/Legal Guardian Printed Name

_____ _____

Client/Legal Guardian Signature Date

ATTENDANCE, CANCELLATIONS, AND DISCHARGE POLICIES (Rev 1/5/23)

Regular and consistent attendance is required in order to show treatment progress and to maintain your scheduled appointment time.

Cancellations must be made with at least 24 hours' notice, or a $45.00 fee will be charged. This applies to clinic, telehealth, and community-based appointments. We understand that due to illness or other unexpected events it may be necessary for you to occasionally cancel a therapy appointment. Please call your therapist or the office manager and leave a message if you reach voicemail. Make up sessions are encouraged.

MISSED OR NO SHOW APPOINTMENTS: A fee of $45.00 will be charged if the 24-hour notice is not given; this fee is charged in an effort to deter unnecessary missed appointments. This fee cannot be billed to your insurance company and will be due and payable prior to your next scheduled treatment session. *Two no show/no call appointments **will** result in removal from the therapy schedule.*

TARDINESS: You have chosen a specific day/time for your therapy appointment. If you arrive late, the treating therapist will determine if there is enough time to proceed with the session, and the session will conclude at the regularly scheduled time. *We reserve the right to remove you/your child from the schedule if you do not consistently arrive at your scheduled appointment time.*

Being absent or tardy both impedes the therapy process and financially impacts our staff and Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center. We also have a long waitlist of families who need therapy services. If you are faced with a scheduling challenge, please see the front desk in order to find a more preferable therapy time.

DISCHARGE POLICY It is the policy of Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center to discharge clients who meet one of the following criteria: no longer demonstrates need for intervention, does not appear to benefit from continued services, is not meeting financial responsibilities to Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center, does not meet the required attendance (as outlined above), is requested by the parent/caregiver, or at the discretion of the agency.

By signing below, I acknowledge that I have fully read and understand the Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center Attendance, Cancellations, and Discharge Policy (updated 1/5/23).

Client Full Name: _____ Date: _____

Client/Parent/Guardian Printed Name: _____

Client/Parent/Guardian Signature: _____

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Telehealth Consent Form

Client's Name: _____ DOB: _____

Legal Guardian's Name: _____

Check all that apply now or in the future.

Visit type(s): ☐ OT ☐ Speech ☐ PT ☐ Neurofeedback

Telemedicine involves the use of electronic communications to enable health care providers at a different location to engage in live two-way video conferencing for the purpose of providing speech/OT/PT services. I understand that electronic systems used during the Telemedicine session will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data (e.g. password protected screensavers, encrypted data files) and to ensure its integrity against intentional or unintentional corruption.

1. **Confidentiality:** I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent as outlined by HIPAA
   (Health Insurance Portability and Accountability Act).
2. **Patient Rights:** I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my child's care at any time, without affecting his/her right to future care or treatment. I will be informed of any other people who are present at either end of the telehealth encounter and have the right to exclude anyone from either location. All confidentiality protections required by law or regulation will apply to my care.
3. **Medical Records:** A contact note will be written during/after your telehealth appointment and will be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

   I hold Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center harmless for interruptions, unauthorized access, technical difficulties, and call termination during our telehealth video calls. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the video/audio connections are not adequate for my situation. It is my preference and/or need for my OT/ST/PT provider to deliver services via telehealth either for medical-health/safety reasons until we are able to meet face-to-face (if related to COVID-19) or parent preference if always covered by insurance.

I understand and consent to participate in Telehealth Services for Speech/OT/PT therapy or Neurofeedback.

_____ _____

Client/Legal Guardian Signature Date

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FINANCIAL POLICY AGREEMENT

Client Full Name: _____ Date: _____

If you have Health Insurance, we want you to receive your full benefit. Our office team can assist you in completing your insurance forms and verifying benefits/coverage. If Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center is in network with your insurance provider, you are responsible for your deductible and the co-payment or coinsurance (the portion insurance does not cover) at the time services are provided. Please note, the portion of the total fees covered by your insurance may be different than the amount quoted on the day of service. You are encouraged to verify your insurance policy benefits. You are responsible for any outstanding balance after insurance has been applied.

By initialing, I understand that I am responsible for the payment of a one-time $100.00 Educational Consultation fee for the initial evaluation. This fee cannot be submitted to insurance and is the client's responsibility.

Initial _____

PAYMENT FOR SERVICES: Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center accepts cash, checks, Visa, MasterCard, Discover, American Express and PayPal.

CONTRACTUAL AGREEMENT:

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW

I understand all client co-payments are due payable at the time services are rendered. I authorize payment directly to Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center for the benefit otherwise payable to me under the terms of any insurance. I understand I am financially responsible for all charges arising from the treatment of the above-named client and any insurance payments will be credited to the account. In the event the bank returns any check given in payment on this account, unpaid for any reason, a $35.00 charge will be added to the account balance each time a check is returned. If all charges are not paid in full within sixty (60) days from the date of service, I agree to pay the service charge of eighteen percent (18%) per month with a twenty-one percent (21%) annual interest on the unpaid balance. If this account is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to attorney's fees and all court costs.

By signing below, I acknowledge that I have fully read and understand the Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center Financial Policy Agreement.

Legal Guardian Printed Name (If Applicable): _____

Client/Legal Guardian Signature: _____ Date: _____

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PRIVACY PRACTICES POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinicians or other treatment team members. *We may disclose PHI to any other consultant only with your specific written authorization.*

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support certain business activities including, but not limited to, sharing your PHI with third parties that perform various business activities (e.g., billing or typing services) only if we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. Your PHI may be disclosed via email, if you have given written permission, for appointment reminders, and to provide information about treatment alternatives or other health-related benefits and services.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose information to family members that are directly involved in you or your child's treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI that we maintain about you. To exercise any of these rights, please submit your request in writing:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask for amendment of the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations.
- **Right to Request Confidential Communication**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice. **Please notify Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center, LLC if you would like a copy. Please also check the appropriate box on the signature page, indicating you received a copy of this notice.

Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center

Written Acknowledgement Form

By signing this form, I acknowledge and agree as follows:

I have been given the opportunity to read Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center's Notice of Privacy Practices policy statement (previous 2 pages), prior to signing this acknowledgement form.

The Privacy Practices policy statement includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center, LLC to treat me and/or my child and to obtain payment for that treatment.

By initialing, I indicate that I ***would*** like a printed copy of Be'med Medical, Speech-Language/Swallowing And Rehabilitation Center's Notice of Privacy Practices Policy.

_____ _____

Name of Client Date

_____

Legal Guardian Printed Name (If Applicable)

_____

Parent/Guardian Signature

BE'MED MEDICAL, SPEECH-LANGUAGE/SWALLOWING AND REHABILITATION CENTER

ADULT CLIENT BACKGROUND INFORMATION

Date: _____

Child's Full Name: _____ Age: ____ Birth Date: _____ Sex: _____

Preferred Name/Nickname: _____

Occupation: _____

How do you find out about us? _____

What is your major concern that led you to seek help? _____

How long have you had these concerns? _____

What others concerns do you have? _____

Please check the areas of your life that are affected by these issues/concerns:

☐ Home ☐ School ☐ Work ☐ Church

☐ Public Places (Please Specify) _____

Other: _____

With whom do you live? _____

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Please check any of the following medical professionals from whom you are currently receiving or have received services, and include any formal diagnoses/recommendations given.

Area of Service	Clinician	Date	Diagnosis/Recommendations
☐ Occupational Therapists	_____	_____	_____
☐ Physical Therapist	_____	_____	_____
☐ Speech Language Pathologist	_____	_____	_____
☐ Vision Specialist	_____	_____	_____
☐ Hearing Specialist	_____	_____	_____
☐ Neurologist	_____	_____	_____
☐ Orthopaedist	_____	_____	_____
☐ Psychologist	_____	_____	_____
☐ Counsellor	_____	_____	_____
☐ Other:	_____	_____	_____

Are you allergic to any medications? ☐ No ☐ Yes

If yes, list allergy and reaction: _____

Are you allergic to anything other than medications? ☐ No ☐ Yes

If yes, list allergy and reaction: _____

List any medications you are currently taking in the columns below. (Use back of sheet if needed)

Name of Medication	**Purpose**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What medical or physical problems do you currently have or have previously had? Mark an X and then describe below.

	Past	**Present**	**If yes, please explain**
Cardiac Problems	☐	☐	
Ear infections, frequent colds	☐	☐	
Poisoning, drug use or overdose	☐	☐	
Hospitalizations or surgeries	☐	☐	
Vision/hearing difficulties	☐	☐	

☐ ☐

Balance/Coordination Issues	☐	☐	
Muscle or Verbal Tics	☐	☐	
Speech disorders	☐	☐	
Serious accidents/Injuries - including concussions and loss of consciousness	☐	☐	
Very sensitive to feel of labels, seams, textures in clothes or food taste, smell, or texture	☐	☐	
Bothered by loud or unexpected noises	☐	☐	
Picky eater	☐	☐	
Shortness of breath	☐	☐	
Headaches	☐	☐	
Dizziness	☐	☐	
Motion Sickness	☐	☐	
Unusual Fears/Worries	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Substance Abuse	☐	☐	
History of Trauma	☐	☐	
Sleep Problems	☐	☐	
Social Problems	☐	☐	
Attention or learning problems	☐	☐	
Significant stressors	☐	☐	

Other:

_____

_____

_____

Are you currently in school? ☐ No If yes, which school do you attend and what are you studying?

_____

Please include anything else you think might be helpful for us to know about.

_____

_____

_____

_____