STACEY LEVY & ASSOCIATES, LLC www.slevyassociates.com
4651 Roswell Rd Suite F-501 ● Atlanta, Georgia ● 30342 ● (678) 358-8140 ● slevy@slevyassociates.com

PERSONAL INFORMATION

Name (First, Middle, Last):	DOB: / /	Age:	Gender:
Address:	Current School: Grade / Teacher Name: Previous School:		
Parent / Guardian 1 Name:	Parent / Guardian 2 Name:		
Phone Parent 1:	Phone Parent 2:		
Email Parent 1:	Email Parent 2:		
Occupation Parent 1:	Occupation Parent 2:		
Which parent is responsible for payment?	Is there a custody / divorce situation we need to be aware of?		
Siblings (name, age)	Physician Name:		
Emergency Contact (in the event parents cannot be reached): Relationship to child:	Emergency Contact Phone Number:		

PAST DEVELOPMENTAL / MEDICAL HISTORY

Medical Diagnosis / Pertinent Conditions:	Current Medications:
Past surgeries (include ear tubes, adenoidectomy, tonsillectomy, frenectomy):	Was your pregnancy with the child complicated? If yes, how so?
Did your child meet speech / language milestones on time? If no, please expand:	Date of last Speech/Language Evaluation (if applicable): Report provided?
Did your child meet gross / fine motor milestones on time? If no, please expand: Did your child crawl before walking?	Date of last Occupational / Physical Therapy Evaluation (if applicable): Report provided?
When was your child's hearing last checked? Vision last checked?	Date of last Psychological Evaluation (if applicable): Report provided?

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Please list any other specialist who has worked with or works with your child:	
Developmental Pediatrician:	Occupational Therapist:
Developmental Optometrist:	Physical Therapist:
Tutor:	Speech-Language Pathologist:

CURRENT CONCERNS

What brings you in for an evaluation today?	
Is there a history of learning disabilities or speech-language difficulties in your family? If yes, please explain:	What are your child's interest and hobbies?
Who can we thank for referring you?	
Please use this space to tell us any other pertinent information:	

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Stacey Levy & Associates (SLA)
Clinical Service and Financial Policies

Child's name_____ **DOB**_____

Parent/Guardian's name_____

Parent/Guardian's signature _____

******Please initial next to each policy verifying that you have read and understand it. Please contact us with questions.**

_____**Attendance / Promptness** Regular attendance is a critical component in assuring effective treatment. Therefore, a commitment to regular attendance is required. If 3 or more sessions are missed, SLA reserves the right to discontinue therapy. SLPs/TUTORs make every effort to be punctual for your appointment. Therefore, sessions cannot be extended in cases of late arrival. You will be charged for the full session if you arrive late.

_____**Cancellation** From time to time circumstances arise which necessitate canceling an appointment. We ask that you inform the SLP/TUTOR at least 24 hours in advance if you are unable to make your appointment. If you must cancel a morning appointment due to sickness, please notify the SLP/TUTOR the evening before or by 8:00am the day of the scheduled appointment.

As part of your financial responsibility we are advising you that Stacey Levy & Associates reserves the right to charge a fee for any appointment that is not kept or not canceled by giving 24 hours advanced notice. If you fail to follow these policies, you will be billed a "Cancellation Fee" of $50. Unforeseen circumstances are anticipated and will be dealt with on a case by case basis. Attempts will be made to provide make-up sessions at the SLP/TUTOR's discretion.

***If your child receives therapy <u>at school</u> and will be going on a field trip, attending a conflicting school program or is not at school for any other reason, or if the school is CLOSED, we must have notification at least <u>24 hours in advance</u> in order to avoid the Cancellation Fee. It is your responsibility to inform the SLP/TUTOR of changes in your child's regularly scheduled session, not the school's responsibility.

_____**Payments** Payment for evaluations are due on the day of the evaluation. Please bring check or cash with you the day of the evaluation. Ongoing therapy services are billed monthly via EMAIL INVOICE. Payments may be made via cash or check made out to Stacey Levy and Associates, or by the online payment option on the invoice. Please include your child's name in the Memo section. **Payment is due by the 15th of the month** following the month the services are provided (i.e., payment for sessions in August are due by September 15th.) A late fee of $25 is charged for late payments.

_____**Insurance** SLA does not bill your insurance company, but we are happy to provide you with the codes and paperwork you need to file the claim yourself. We do not have direct contact with your insurance company without your request. Please note that not all speech and language issues are covered by insurance, and we are ALWAYS considered an "OUT OF NETWORK PROVIDER."

If you have a need for SLA to spend additional time helping with your out-of-network insurance claim, including making a phone call to your insurance provider, any time spent over 20 minutes on phone calls or specific forms required by your insurance company, will be billed to you at the prorated rate of $125/hour. This will only be completed at your request.

_____**Release of Information** A file is established for each client containing reports and information regarding services. We often work cooperatively with other community professionals in coordinating services. To protect the confidentiality of patient records, we require your written permission (via paper or email) before we communicate in any form with others about aspects of your care.

_____ **Waiting Room Etiquette** We know that your child's time with the SLP/TUTOR is valuable, so please help us make the most of it by observing proper waiting room etiquette. We provide toys and books in the waiting room for siblings. It is your responsibility to keep siblings quiet and put toys and books away. If you need to make phone calls during your child's session, please do so outside of the building.

___ **Leaving During Sessions** If you leave the office during your child's session, please do not go far. Always inform the SLP/TUTOR you are leaving and leave a cell phone number in case of emergency. Please return to the office at least 10 minutes prior to the end of your child's session.

_____**Student Observation** Periodically, our SLP/TUTORs serve as therapy models for students in undergraduate and graduate Speech-Language Pathology programs. Students are required to observe a variety of diagnostic and therapy sessions as part of their learning experience. Observations are coordinated by Stacey Levy and/or the Clinical Director. Students are aware of their ethical responsibilities regarding confidentiality of information. Clients have the option of granting permission to be observed in therapy; please notify us if you do not wish to participate in student observations.

_____**Audio/Video Recording** Sessions are sometimes recorded as a means of assessing progress, evaluating the effectiveness of therapeutic approaches, or as a tool in therapy. Client's consent to being recorded and confidentiality is assured. Recordings or other information NEVER leave the facility without your written consent.

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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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law.

We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Stacey Levy & Associates, LLC
4651 Roswell Rd Suite F501
Sandy Springs, Georgia 30342
678-358-8140
slevy@slevyassociates.com
For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 877-696-6775 (toll-free)

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*** Please sign and return this page of the HIPAA form only.

Notice of Privacy Practices Receipt

I, _____, on behalf of _____
(Name of Parent/ Legal Guardian) (Child's Name)

have received a copy of Stacey Levy & Associates' Notice of Privacy Practices with an effective date of _____, 20___.

Signature _____ Date _____
(Parent/ Legal Guardian) (Relationship)

Signature of Therapist/Witness _____ Date _____

In addition to the aforementioned entities, I give permission for Stacey Levy & Associates to (Check all that apply):
____ Leave detailed messages about therapy on my home or cell phone answering machine or voicemail.
____ Communicate with my child's school/daycare teachers and other practitioners (Occupational Therapist, Physical Therapist, Psychologist, tutor, etc.) about my child.
____ Use a communication notebook at school/daycare/house to communicate with other therapists, teachers, caregivers about my child.

You may communicate confidential information, including services, to me by the following means:

U.S. Mailing Address: _____

_____

Email Address: _____

Patient's Name: _____ Patient's DOB: _____

Telephone Number: _____Fax Number: _____

Designated/Authorized Next of Kin: _____

Designated Signature: _____

Relationship to Patient: _____ Date_____