CSTC Therapies Inc.

SPEECH THERAPY
PATIENT REGISTRATION FORM

PATIENT INFORMATION DATE:

CHILD'S NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____-_____-_____ SEX: M ☐ F ☐

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

SCHOOL: _____ GRADE/CLASS: _____

TEACHER: _____

LANGUAGES: English (___%) ; _____ (___%) ; _____ (___%)

DIAGNOSIS:_____ PRECAUTIONS/CONTRAINDICATION FOR THERAPY_____

ANY KNOWN ALLERGIES, IE FOOD, LATEX…_____

HOW DID YOU HEAR ABOUT US? Dr._____Website_____Friend_____ Other_____

PARENT/LEGAL GUARDIAN

NAME:_____SEX: (M F) MARITAL STATUS:_____
LAST FIRST MI

RELATION TO PATIENT:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

E-MAIL ADDRESS:_____ DO YOU CHECK THIS REGULARLY? YES NO

DAY PHONE: (____)_____EVE PHONE:(____)_____CELL PHONE:(____)_____

DRIVERS LICENSE: _____ STATE: _____ DATE OF BIRTH: _____- _____ - _____

EMPLOYER_____ BUSINESS ADDRESS_____

NAME:_____SEX (M F) MARITAL STATUS:_____
LAST FIRST MI

RELATION TO PATIENT:_____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

E-MAIL ADDRESS:_____ DO YOU CHECK THIS REGULARLY? YES NO

DAY PHONE:(____)_____EVE PHONE:(____)_____CELL PHONE:(___)_____

DRIVERS LICENSE: _____ STATE: _____ DATE OF BIRTH: _____- _____ - _____

EMPLOYER_____ BUSINESS ADDRESS_____

44025 Pipeline Plaza, Suite 105, Ashburn VA 20147
Phone: 703.723.7270 Fax: 703.740.8758 www.cstctherapies.com

CSTC Therapies Inc.

PATIENT'S PRIMARY PHYSICIAN

PHYSICIAN NAME ds_____

PRACTICE NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE: (_____)_____FAX: (_____)_____

PRIMARY INSURANCE

PRIMARY INSURANCE POLICYHOLDER: _____

RELATION TO PATIENT: _____ BIRTHDATE: _____ - _____ - _____ DRIVERS LIC. #:_____

INSURANCE COMPANY: _____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE: (_____)_____FAX: (_____)_____

SUBSCRIBER I.D. #: _____ GROUP #: _____

ACKNOWLEDGEMENTS

HIPAA: Notice of Privacy Practice

By signing this statement you are acknowledging that you have had the opportunity to receive CSTC Therapies Inc HIPAA Notice of Privacy Practices:

PATIENT NAME (printed):_____

Signature: d_____Date:_____

Parent/Legal Guardian or self

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CSTC Therapies Inc.

INSURANCE CERTIFICATION AND RELEASE AUTHORIZATION

This is to certify that I, _____ authorize CSTC Therapies Inc (CSTC) to apply for benefits for services rendered to me or my child by the speech pathologists, occupational therapists, and /or physical therapists at CSTC Therapies Inc. If payment is not made to CSTC for any reason, I understand and agree that I am responsible for payment in full for any/all services that I have received from CSTC Therapies Inc.

I further certify that the information I have provided concerning my insurance coverage is correct. I also realize that confirming coverage of insurance benefits is a courtesy done on my behalf by CSTC Therapies Inc. I understand and agree that I am ultimately responsible for checking with my insurance company/carrier as a follow-up, and that failure to do so may result in a lesser payment or no payment at all.

I understand and agree that any and all referral documentation and or information, if required by my insurance carrier, is MY RESPONSIBILITY to obtain and provide to CSTC Therapies Inc by no later than the date of my appointment.

I further authorize CSTC Therapies Inc to release any information, including medical information for this or any related claims to any insurance company or reimbursing agency in order to determine benefits to which I may be entitled.

I have read, understand, and agree to the above:

_____
Signature of Responsible Party

If the patient is under the age of 18, please complete the following:

The undersigned is a parent/guardian of the patient and executes this form on their behalf:

_____
Signature of parent/guardian

_____
Please print name and relationship to patient

Date form completed: _____

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CSTC Therapies Inc.

PATIENT FINANCIAL AGREEMENT

We are pleased you have chosen CSTC Therapies Inc. for your speech therapy care. We are dedicated to providing our patients with the best possible care and service, while keeping the costs to you from increasing. We do not render service in order to collect money, but we must collect in order to render service. We ask your help by understanding and cooperating with our financial policy.

We believe that our Patient Financial Agreement is important and it is our responsibility to inform you of charges and our payment guidelines prior to treatment. Determining costs for insured patients is more difficult and less accurate. Your insurance is a contract between your employer and an insurance company. Benefits received are based on the terms of the contract negotiated between your employer and the insurance company, and not CSTC Therapies Inc. The goal of insurance policies is to provide basic care and many needed services may not be covered. Our office will do everything possible to help you understand and make the most of your insurance benefits. As a courtesy, our office will complete and submit your insurance forms to achieve the maximum reimbursement to which you are entitled. Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your insurance policy so that you are fully aware of coverage and any limitations of the benefits provided. We will gladly discuss our payment options with you before beginning your treatment.

Insurance:
We participate with certain insurance plans. It is your responsibility to provide us with your correct and current insurance information at the time of your visit and to make sure that we are providers with your specific plan. If you fail to present the correct and current insurance information at the time of your visit, then you agree to be responsible for 100% of our usual and customary charges for your visit.

If we participate with your plan, we will provide the service if filing a claim to your insurance company for office charges, unless we have received prior notification of non-covered services. Those services, along with all co-pays and deductibles are the patient's responsibility and must be paid at the time of your visit. Any fees not billable to insurance will be disclosed in advance, and you will be required to sign a waiver acknowledging our policy before services will be rendered. In addition, you will be given the necessary paperwork to file to your insurance company.

We will file the initial claim to your insurance company. Our office policy is to allow for one subsequent filing. If, after the second filing the claim remains unpaid, then the balance will be transferred to your responsibility and payment will be expected upon receipt of a statement. We will work with you to ensure that our services have been billed correctly. The ultimate responsibility for the timely payment for services rendered is yours. If you are owed a refund, the refund will only be issued when your account balance is zero.

If we do not participate with your insurance, payment in full will be due at the time of your visit.

Payment for services performed:
Our office accepts cash, personal checks, Visa, MasterCard, and Discover. All copays need to be paid at the time of service. There is a $40.00 charge for returned checks. Any patients requiring correspondence via certified mail will be charged a $20.00 fee. All outstanding balances are due

within thirty (30) days, unless prior arrangements are made with the billing office. All copays must be paid by the end of the month. Any balance on copays left at the end of the month will be charged a finance charge of 10% of your remaining balance. All balances over 90 days may be sent to a collection agency. You will be financially responsible for all collection and legal fees incurred by CSTC Therapies Inc in the collection of your delinquent balance.

The patient and/or responsible party has received, read and understand the financial agreement. The patient and /or responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with whom this office has a contracted agreement, the patient and /or responsible party agree to pay all applicable co-payments, and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to the patient, which is not considered to be covered by insurance.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY SET FORTH BY CSTC THERAPIES INC AND AGREE TO THE TERMS. I ALSO UNDERSTAND THAT THE TERMS OF THIS POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____ _____

Parent's Signature Child's Name

CSTC Therapies Inc.

Cancellation Policy

Regular attendance is essential for your child's growth in therapy. Please remember that once a therapy time has been set, that time is reserved for you. However, we understand that there are times when you cannot make a therapy session. Our cancellation policy is below. Please read it over and sign below. If you have any questions, please feel free to ask your therapist.

- **No more than 2 missed therapy sessions may occur within a quarterly period.**
  - Our quarters are defined as follows: Q1 = January, February, March; Q2 = April, May, June; Q3 = July, August, September; Q4 = October, November, December
  - If more than 2 cancellations occur, it is your responsibility to reschedule a make-up session during a time that your therapist has availability in order to avoid the missed appointment fee of $35 per missed therapy session.
  - Rescheduled therapy sessions must occur within the same quarter as the cancelled session. Any sessions not made up by the end of the quarter will be billed at the end of the quarter.
- **No Shows - A therapy session missed with no prior notice or phone call (at least 30 minutes before the session starts) will be charged $65 for the missed therapy session. There will be no chance to make-up a no-show.** Please respect your therapist's time and email or call them if you have to cancel. Your therapist's email is theirname@childrens-speech.com. **If 2 or more no-shows occur within a quarter, your spot may be removed from the schedule. Please call us back to reschedule a permanent therapy time**.

- All cancellation fees will be billed directly to client. **No cancellation fees will go through your insurance company.**

- **Our answering machine is on 24 hours a day, 7 days a week**. You can call at any time during the day or night to notify CSTC Therapies that you need to cancel your appointment.

- **Pick Up - If you cannot pick your child up on time, there will be a charge of $25 each 5-minute increment that you are late. This will not be charged to your insurance company.**

- **Inclement Weather** – CSTC Therapies does not follow the school schedule or closing schedule for inclement weather. CSTC Therapies will inform you of an office closing or therapy cancellation via email and/or phone.

By signing below, I acknowledge receipt of the cancellation policy and agree to the terms stipulated above.

Parent's Signature	Child's Name	Date

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CSTC Therapies Inc.

MEDICAL HISTORY:	YES	NO
Was mother's condition during pregnancy good to excellent?	____	____
Were medications taken during pregnancy? If yes, what?	____	____
Were there any complications/illnesses during pregnancy? What?	____	____
Was your baby born within two weeks of due date?	____	____
Was your child adopted?	____	____
Were labor and delivery normal?	____	____
Was labor induced?	____	____
Was there evidence of injury or poor health at birth?	____	____
During the first month of life, was child's health good?	____	____
Were there any feeding problems as a baby or toddler?	____	____
Was your child's activity level average as a baby and toddler?	____	____
Does your child have allergies or are allergies suspected?	____	____
Was development of teeth normal?	____	____

**Please comment on any of the above areas that were unusual:

_____

_____

Has your child had ear infections? List frequency and severity. Were antibiotics effective in treating the problem?

_____

Has your child had hearing testing or tympanometric testing? When and where? Does your child have tubes in his ears? Do you have any concerns about his hearing?

_____

List any additional illnesses, injuries and hospitalizations your child has had, including severity of illness and frequency. List any medications that are taken regularly.

_____

_____

DEVELOPMENTAL HISTORY:

Does your child exhibit or has he exhibited any of the following behaviors? If so, please indicate age and any attempts to alter his behavior.

Behavior	*Age*	*Comments*
Excessive Shyness	_____	_____
Thumb/Pacifier Sucking	_____	_____
Difficulty separating from parents	_____	_____
Face Twitching	_____	_____
Strong Fears/Nightmares	_____	_____
Temper Tantrums	_____	_____
Sleep Difficulties or Bedwetting	_____	_____
Difficulty sitting still	_____	_____
Inability to complete activities	_____	_____
Attention Problems	_____	_____

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Does your child play well with other children? Do you have any concerns about your child's play?

_____

Does your child have any academic difficulties?

_____

When did your child first achieve the following motor milestones? Please comment on difficulties or concerns.

Milestone	*Age*	*Comments*
Crawling	_____	_____
Sitting Unassisted	_____	_____
Walking	_____	_____
Holding a Cup	_____	_____
Using a Spoon	_____	_____
Using Crayons	_____	_____
Toilet Training	_____	_____

When did your child first exhibit the following speech/language skills?

Milestone	*Age*	*Comments*
Babbling	_____	_____
Imitating Words	_____	_____
Using first word meaningfully	_____	_____
Putting words together	_____	_____

Did your child's speech/language development seem to develop normally and then stop or regress?

_____

Does (s)he understand what is said to her?

_____

Does (s)he follow spoken directions?

_____

Does (s)he talk in (check one) single words ☐; phrases ☐; complete but grammatically incorrect sentences ☐; complete grammatically correct sentences ☐.

Does (s)he retell stories or experiences that can be understood? _____

Does (s)he often hesitate and/or repeat sounds and words? _____

Is his/her speech (check one) too fast _____, too slow _____, average _____ ?

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CSTC Therapies Inc.

ENVIRONMENTAL HISTORY:

Names of Siblings | Birth Dates

_____ _____

_____ _____

_____ _____

Others in the Home _____

Have any other family members or relatives had the following difficulties?

Difficulty	*Yes?*	*Relationship to Child*
Speech or Language Problem	☐	_____
Hearing Problem	☐	_____
Learning Disability	☐	_____
Reading Problem	☐	_____
Emotional Problems	☐	_____
Other	☐	_____

PRIOR EVALUATIONS/THERAPY:

Has your child been seen by any other specialists? Yes ____ No _____

Please list any specialists your child has seen for medical, developmental, or educational concerns. Please list current therapists, if any.

_____

_____

_____

_____

Please add any additional comments or information that we may need to know in order to better serve your child. Thank you.

_____

_____

_____

_____

_____

_____

**Please return this form along with copies of any previous evaluations, educational plans or other reports you would like us to consider when assessing or treating your child.

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CSTC Therapies Inc.

REVIEW OF CSTC POLICIES

1. **PAYMENT IS DUE AT THE TIME OF SERVICE** unless other arrangements have been made with our office.
2. Third party reimbursement should be paid directly to parents unless the insurance carrier requires that payment be made to **CSTC** directly. You are obligated to pay us for all services provided on your behalf, regardless of whether or not other services are covered by your policy with your insurance carrier. You are responsible for providing the required information necessary for obtaining insurance coverage and authorization. We will be happy to assist you.
3. Regular attendance is essential for your child's growth in therapy. Your child's appointment time has been exclusively reserved for you and your child. However, should you need to cancel a session, please try and reschedule your cancelled session. If more than 2 cancellations occur and are not made up per 3-month period, a $35 missed therapy fee will be applied.
4. **A therapy session missed with no prior notice or phone call (No show) will be charged $60 for missed therapy session**. Exception to this charge policy will be considered if the client makes up the session at a time available in the therapist's schedule.
5. All cancellations will be billed directly to client. **No cancellations will go through your insurance company.**
6. **If 3 or more no shows occur in a 3-month period, CSTC Therapies reserves the right to discontinue treatment.**
7. Please note that **we do NOT follow the school calendar** regarding holidays and inclement weather. Please confirm appointments with your therapist if you have any questions regarding your therapy schedule.
8. The waiting area is equipped with toys and books for your child's use while in therapy as well as for anyone's use while in the waiting area. Please keep the waiting area reasonably quiet and assist the children with toy cleanup.
9. Please give your therapist at least 2-weeks notice if you need a written report/letter, etc. for an IEP meeting or other professional meeting.

By signing below, I acknowledge receipt CSTC Policy Statement and agree to the terms stipulated above.

_____ _____

Parent's Signature Child's Name

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CSTC Therapies Inc.

Release of Information

I give permission for Children's Speech Therapy Center to release information regarding

_____ to _____
(child's name) (name of doctor, school, therapist, etc.)

_____
(doctor's, school's, therapist's address and phone number)

_____ _____
(parent/guardian's signature) (date)

Videotaping and Photography

Use of videotaping and/or photography is often used in order to aid in the assessment, evaluation, and/or treatment of your child. These photos and videos are used solely for the purposes of visual aids during therapy, documentation and assessment of progress over time. CSTC Therapies will protect all videos and photographs and will follow all confidentiality for our clients.

_____(Please initial) I give permission for my child to be videotaped and/or photographed for the aforementioned purposes and will not be shared with any person outside this practice.

_____ _____
Parent Signature Date

Email

_____(Please initial) I give permission for CSTC Therapies to contact me via email regarding my child's speech therapy session.

_____(Please initial) I give permission for CSTC Therapies to send documentation such as evaluations, progress reports, and/or treatment plans via email.
s

_____ _____
Signature Date

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CSTC Therapies Inc.

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.

Who Will Follow This Notice
This joint notice applies to our staff, business associates and therapists while they are treating you in our facility. It describes how we will use and share your information, how we are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your health or condition and related health care services. We are required to abide by the terms of the notice currently in effect. If you have questions about any part of this notice or if you want more information about our privacy practices, please contact our HIPAA Compliance Officer at (703) 723-7270.

I. How we may use or share your health information. We are committed to protecting the privacy of your health information. The law permits us to use or share your health information for the following purposes:

1. *Treatment.* We may use or share your PHI with physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

2. *Payment.* We may use or share your PHI to obtain payment for your health care services. For example, obtaining approval for payment of services from your health plan may require that your PHI be shared with your health plan. We may also provide your PHI to our business associates, such as billing companies.

3. *Health Care Operations.* We may use or share your PHI in order to operate our facilities. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. *Notification and Communication with Family.* We may release your PHI to a relative, close friend, or any other person you identify, information that directly relates to that person's involvement in your health care unless you object. If you are unable to agree or object to the release, we may release information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or release PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care to tell them your location or general condition. Finally, we may use or share your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and releases to family or other individuals involved in your health care.

5. *Required by law, court, or law enforcement.* We may release PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with crime; or when ordered by a court.

6. *Public Health.* As required by law, we may release PHI to public health authorities for purposes related to preventing or controlling disease, injury or disability; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

7. *Research.* We may release your health information to researchers conducting research that has been approved by an Institutional Review Board.

8. *Specific Government Functions.* We may share your health information for military or national security purposes.

9. *Appointment Reminders & Health Related Benefits.* We may use your PHI to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

10. Diagnostic and therapeutic information regarding psychiatric, drug/alcohol abuse, or sexually transmitted diseases (including HIV status) will not be disclosed without your specific permission, unless required by law.

II. Your Health Information Rights

1. *You have the right to request a limit on certain uses and releases of your health information.* We will consider your request, but are not required to accept it. These requests must be in writing and submitted to our HIPAA Compliance Officer.

2. *You have the right to choose how you receive your health information.* You have the right to ask that we send information to you at an alternative address or by other means (for example, telephone instead of mail, post office box instead of home address). We must agree to your request so long as we can easily provide it in the format you requested. These requests must be in writing.

3. *You have the right to see and get copies of your health information, in most cases.* These requests must be in writing.

4. *You have a right to request that we correct or update information that is incorrect or incomplete.* We are not required to change your health information. If we deny your request, we will provide you with information about our denial and how you can disagree with the denial. These requests must be in writing.

5. *You have a right to receive a list of disclosures we have* made except that we do not have to account for the disclosures described under treatment, payment, health care operations; information provided to you; information released based on your written authorization; directory listings; certain government functions; disclosures of a limited data set (which may only include date information and limited address information); and to correctional institutions or law enforcement in custodial situations. These requests must be in writing and must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.

6. *You have a right to get a paper copy of this Notice of Privacy Practices.* You may request a copy of this notice at any time.

III. Changes to this Notice of Privacy Practices
We reserve the right to change this Notice of Privacy Practices at any time in the future. We reserve the right to make the changed notice effective for health information we already have about you as well as any we receive in the future. We will post a current copy of the Notice. Upon request, you may obtain a copy of the current notice by contacting our HIPPA Compliance Officer at (703) 723-7270.

IV. When We May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

V. Complaints
If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Compliance Officer or with the Secretary of the Department of Health & Human Services. To file a complaint with our HIPAA Compliance Officer, call (703) 723-7270.

You will not be penalized for filing a complaint.