DATE_____ HOME PHONE_____

~PATIENT INFORMATION~

Name_____ DOB_____

Address:_____ ☐ Male ☐ Female

City_____ Zip Code_____

Patient Employer/School and grade_____

Parents' names, if patient is a minor

Mother_____ Father_____

Cell _(_____)_____ Cell:___(_____)_____

Permission to text regarding appointments to these cell numbers? Yes No

Email:_____ Email_____

Child lives with ☐both parents ☐ mother ☐father ☐ other_____

In case of emergency, who should be notified?_____

Phone_____

Over the Mountain speech

Location: 4231 Dolly Ridge Road
Vestavia Hills, AL 35243

Phone: (205) 531-8998
Fax: (205) 970-4122

www.otmspeech.com

Speech/Language Case History

Child's Name_____ Date of Birth_____
Address_____ Home Phone_____
_____ Cell Phone_____
Parent Name_____ Today's date_____
Email: _____

Were there any problems related to the pregnancy or birth of this child? Was the pregnancy full term? Please describe any problems.

Does your child have a medical diagnosis relating to speech/language delays? _____ If yes, what is the medical diagnosis? _____

Is there a history of frequent/chronic ear infections or hearing loss? _____
Is there a history of pacifier use or thumb sucking after infancy?_____
Has your child been diagnosed with a tongue tie?_____
Do you suspect that your child has any sensory processing problems?_____ If yes, please explain

_____

Please list any health problems and/or regular medications taken _____

_____

At what age did your child: Begin to use at least one word? _____
Begin saying 2 or more words together?_____
Talk well enough to be understood by others? _____

Has your child ever received speech therapy? _____ When? _____

What were the goals of therapy? _____

Is English the primary language spoken in the home? _____ What other languages are used at home or school?_____

What grade is your child in now? _____ Name of school_____

Has your child repeated a grade? _____ Which one? _____

Does your child receive special education services? _____ For what? _____

_____

What is your concern with regard to your child's speech and/or language skills? _____

_____

_____

Please describe any academic or social problems/concerns_____

_____

_____

Does your child have difficulty understanding age-appropriate humor?

Does your child have any close friends of the same age?

Does your child show understanding of how other people feel?

Does anyone in the family (parents, grandparents, siblings, aunts, uncles, cousins) have speech or learning problems? _____ Please describe_____

_____

What are your goals/expectations for speech therapy?
_____

_____

May we have your permission to share test results, therapy notes, evaluations, and information about your child with your child's physician? _____ yes _____ no

If yes and you would like the information to be shared, please give physician's name, number, and address:

_____

May we have your permission to share test results, therapy notes, evaluations, and information about your child with your child's teacher or other school personnel? _____ yes _____ no

If yes and you would like the information to be shared, please give specific teacher names, number, and school address:

_____

Please list any other schools, personnel, or agencies with which we may share this information:

_____

_____

I give my permission for my child _____ to be evaluated and/or treated by Over the Mountain Speech, Language, and Learning Services, LLC. I give permission to share information with the above parties as indicated.

Signature _____ Date _____

Relationship to child _____

Location: 4231 Dolly Ridge Road
Vestavia Hills, AL 35243
Mailing: 1050 Lake Colony Lane
Vestavia Hills, AL 35242
Phone: (205) 531-8998
Fax: (205) 970-4122

www.otmspeech.com

Attendance Policy

Thank you for choosing Over the Mountain Speech, Language, and Learning Services. We want to provide the best possible services to all of our clients. We will do our best to schedule appointments that meet your needs. Regular attendance is important to your/your child's success. We ask that you follow the attendance policies outlined below:

1. **Cancellations:** Please call us at least 4 hours in advance to cancel your appointment. We reserve the right to charge a $25 fee if you do not give us 4 hours' notice. Insurance will not cover this fee.
2. **Missed Appointments:** If you cancel or do not attend 2 sessions in a row, we may put your services on hold until scheduling problems can be worked out. Missed appointments are subject to full fee for service, which is not covered by insurance.
3. **Late for Appointments:** If you are more than 10 minutes late for your appointment, we reserve the right to cancel the appointment and consider it a missed appointment (see policy for missed appointments above). If you are late for 2 or more sessions, we may put your services on hold until scheduling problems can be worked out.
4. **Clinician Cancellations:** If your speech-language pathologist is not able to attend your appointment, you will be contacted as soon as possible. Please be sure that our office knows the best way to reach you. Every effort will be made to reschedule your appointment in a timely manner.

To cancel an appointment, call our office at (205) 531-8998 or your individual therapist

or e-mail otmspeech@bellsouth.net

☐ I agree to the attendance policies outlined above.

Print Patient's Name _____ Date _____

Patient or Parent/Guardian Signature _____

Relationship to Patient _____

Location: 4231 Dolly Ridge Road
Vestavia Hills, AL 35243
Mailing: 1050 Lake Colony Lane
Vestavia Hills, AL 35242
Phone: (205) 531-8998
Fax: (205) 970-4122

www.otmspeech.com

Payment Policy: Insurance and Self Pay

Thank you for choosing Over the Mountain Speech, Language, and Learning Services (OTM Speech) for your speech-language pathology needs. This is an agreement between OTM Speech and you for payment of services provided. By signing this agreement, you are agreeing to pay for all services provided to you or your family member.

Please read the following information carefully.

Over the Mountain Speech, Language, and Learning Services does not bill insurance companies for evaluations and treatment, and therefore are "out of network" for insurance policies that provide for speech therapy services. We will provide you with the information you need to submit a bill to your insurance company, if needed.

If you plan to submit bills to your insurance company, you should:

- Check with your insurance company before your first visit to find out what speech and language services they will pay for.
- Find out what information the insurance company needs.
  - You may need a note from your doctor, called a referral. You may need permission from the insurance company, called pre-authorization.
  - Referrals and pre-authorizations do not guarantee that insurance will pay for services.

Payment Options:

- Payment is due at the time of service. We accept cash and checks. Credit card payments are not accepted at this time.

Or

- You will be billed for services at the end of each month. Payment is due within 14 days of receiving our bill. We accept cash or checks. *Please do not give your payments to your therapist; they should be mailed to the office mailing address as noted above.*
- We are happy to talk about other payment arrangements, if needed. Talk to us ahead of time to make payment arrangements. Please don't wait until you are not able to pay to talk to us.

Rate:

The current rate for speech/language therapy is $48.00 per half-hour session, with additional minutes billed at 15-minute intervals for $24.00 each. If sessions are less than 30 minutes, the base rate of $48 still applies.

Returned checks:

- You will be charged a $30 fee for each returned check.
- You will be asked to bring cash to the office to cover the amount of the returned check and the fee.

Past due accounts:

- You are expected to pay in full within 14 days of receiving our bill. Accounts 30 days past due will be charged an 18% fee.
- Accounts 3 months past due will be sent to a collection agency. You will be responsible for collection costs, as well as attorney fees and court costs.

_____

Patient's Name

I agree to the payment policies outlined above.

_____ _____

Patient or Parent/Guardian Signature Date

Address:_____

_____

Email:_____

Telephone: Cell _____

Home_____

Work_____

Location: 4231 Dolly Ridge Road
Vestavia Hills, AL 35243
Mailing: 1050 Lake Colony Lane
Vestavia Hills, AL 35242
Phone: (205) 531-8998
Fax: (205) 970-4122

www.otmspeech.com

March 18, 2020

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 Privacy Notice tells you about your rights regarding speech therapy records in this private practice. One copy of this Privacy Notice is for you to keep.

1. What are health care records in this speech therapy practice?

- Your child's health care records may include:
  - notes about each speech therapy visit
  - test forms
  - speech samples
  - questionnaires
  - reports from other agencies that you have provided
  - audio- and video- recordings of testing or speech samples
  - e-mails sent to you
  - e-mails that you send to Over the Mountain Speech
  - e-mails exchanged with a school-based speech language pathologist
  - e-mails with other professionals such as lawyers, OTs, PTs, or reading specialists
  - notes about phone conversations with you or other professionals
  - any other documentation related to speech/language evaluation, treatment, and professional communications

- By participating with Over the Mountain Speech, you agree to allow video- and audio- recordings as well as formal and informal assessments when appropriate to assess therapy progress or investigate the influence of related skills on communication.

- Video- and audio-recordings are erased after they are transcribed. No one else watches and/or listens to audio- or video-recordings without your written consent.

- All records are stored either in a locked file drawer or in a computer and/or smart phone that is password protected.

- 2. What information could these records contain?

  - names and contact information such as address & phone number
  - descriptions of speech therapy activities at each visit
  - notes about your child's performance
  - notes about designing future speech therapy activities
  - any other relevant information, such a parent's or child's comments about attempts at completing carryover activities
  - copies of receipts for payments
  - Social security numbers, health insurance information, or any other financial information from parents is NOT collected.
  - Personal checks are deposited promptly and no information is copied or collected from them other than name, address, and phone number.

3. Information may be shared with a therapist or teacher contracting with Over the Mountain Speech to provide services for your child. No information is shared with anyone or any agency outside of Over the Mountain Speech without your written consent unless legally required to do so.

- The parent who brings the child to the session and signs the therapy agreement form and the Notice of Privacy Practices form will be provided with all written information such as an evaluation report, progress reports, and homework suggestions either in person or by USPS delivery.
- Over the Mountain therapists and teachers will not forward any reports or talk by phone or e-mail with any other person about you or your child without your written consent, unless legally required to do so.
- If you or your child see your therapist or teacher in a public place, the therapist or teacher will not discuss your child's program and/or progress unless you acknowledge and initiate the conversation. Appointments should be made to discuss your child's needs privately if concerns arise.
- Over the Mountain therapists and teachers will not acknowledge their professional relationship with you or your child on any social media.

4. You have a right to access your speech therapy records. Two weeks' notice is required for provision of records.

March 18, 2020

In response to the nationwide public health emergency due to COVID-19, OTM Speech is offering the possibility of remote services via platforms such as Facetime, Facebook Messenger, and Zoom.

The following notice was posted on March 17, 2020, by the US Department of Health and Human Services on their website at
https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules).
During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.
OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.
A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients. OCR is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

OTM Speech is committed to maintaining your privacy regarding and during treatment. It is understood, however, that use of third party applications potentially introduce privacy risks. OTM Speech will continue to monitor the ability to use such platforms as allowed by the Office for Civil Rights at the Department of Health and Human Services.

I have read, understand, and agree to this Notice of Privacy Practices.

_____ _____
Parent date

_____ _____
Printed name Child's Name

COVID-19 PANDEMIC NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision-maker for mine and my child's health care. Part of this office's role is to provide me with information to assist in making informed choices. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving in office care, I confirm and understand the following: (initial in all places):

- I understand that treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- Due to the frequency and timing of visits, the attributes of the virus and the characteristics of the speech therapy provided which may make social distancing or wearing masks impossible, I understand that there may be an elevated risk of contracting the virus simply by being in a healthcare office. _____
- I confirm that neither my child nor anyone in our household is experiencing any of the following symptoms of COVID-19 listed below:
  - Fever or chills____
  - Shortness of breath or difficulty breathing____
  - Cough____
  - Fatigue____
  - Body aches____
  - Headache____
  - Runny nose____
  - Sore throat____
  - Loss of taste or smell____
  - Nausea, vomiting, or diarrhea____
- I understand travel increases the risk of contracting and transmitting the Coronavirus. I verify that my child has not in the past 14 days traveled: (1) outside the United States to countries that have been affected by COVID-19; or (2) domestically within the United States by airline, bus, or train. _____
- I agree that if my child or other household member begins to experience any of the above symptoms, travels to affected areas, or tests positive for COVID-19, I will immediately contact this office and cancel my future appointments until cleared by his/her physician. _____
- I understand that the staff may be asking me questions regarding any symptoms my child or other household members may have as well as any travel they may have undertaken before each visit. _____
- I have been informed that OTM Speech has implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand that there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to OTM Speech staff at your offices to proceed with providing care. _____

I CONFIRM THAT I HAVE READ THE NOTICE ABOVE AND UNDERSTAND AND ACCEPT THIS INCREASED RISK OF CONTRACTING THE COVID-19 VIRUS. I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING IN-OFFICE CARE DURING THE COVID-19 PANDEMIC. I ALSO ACKNOWLEDGE THAT I COULD CONTRACT THE COVID-19 VIRUS FROM OUTSIDE THIS OFFICE AND UNRELATED TO MY VISIT HERE. BY SIGNING BELOW, I AGREE WITH THE CURRENT CARE AS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE FROM ALL PROVIDERS IN THIS OFFICE FOR MY CONDITION AND FOR ANY FUTURE VISITS FOR WHICH I SEEK CARE FROM THIS OFFICE.

_____ _____

Patient Signature Parent/Guardian Signature

Name_____ Name_____

Date_____ Date_____