Patient Information and Consent

Patient Information

Patient First Name	Last Name	M/F	DOB

Patient Street Address	City	State	Zip Code

Parent /Guardian Information

Legal First Name	Legal Last Name	Suffix	Relationship to Patient

Street Address (if different from patient)	City	State	Zip Code

Primary Email	Secondary Email

Home Phone Number	Primary Mobile Phone	Secondary Mobile Phone

Emergency Contact Information

Contact Name	Phone Number	Relationship to Patient

Primary Care Doctor	Location	Phone Number

How did you first hear about Kidmunicate?

We want to help as many kids as possible. Understanding how you found Kidmunicate can help us help more kids like your child. Thank you.

Check all that apply:

☐ Referral from a doctor.	☐ Web Search (i.e. Google)	☐ Display ad (Banner ad)
☐ Referral from a friend.	☐ HealthGrades	☐ Google+
☐ Referral from a teacher.	☐ Yelp	☐ Twitter
☐ Referral from an OT or PT.	☐ Facebook	☐ Other _____

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Insurance Information

Policy Holder's Name	Insurance Company

Policy Number	Group Name	Group Number

Street Address	City	State	Zip Code

Social Security Number	Date of Birth	Relationship to Patient

Home or Mobile Phone Number	Employer

Consent to Treatment

- I voluntarily consent to any and all recommended diagnostic procedures and treatment provided by Kidmunicate LLC, its clinicians and other personnel.
- I am fully aware that speech, language and feeding therapy is not an exact science and I am aware that no guarantee has been or can be made as to the results of the treatments at Kidmunicate LLC.
- I authorize payment of benefits to Kidmunicate LLC or designee for services rendered.

Signature	Date

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Financial Responsibility and Payment Terms

We are in the business of caring for kids. That is our passion, but it is a business. So, we hope that you will help us by following these payment terms for speech therapy.

- I verify that the above insurance information is true and correct to the best of my knowledge. I will notify Kidmunicate, LLC of any changes in the above information within 30
- I understand that any co-pay, coinsurance and private pay fees need to be paid at the time of the service unless an alternative payment schedule has been negotiated.
- I understand that I am ultimately responsible for any fees not covered by insurance providers.
- Any unmet deductibles will be invoiced after the claim is processed.
- If a balance is incurred, for whatever reason an invoice will be sent to you via email. This invoice needs to be paid upon receipt.
- Balances over 30 days old will be assessed a $10 late fee and $10 more for each additional 10 days late.
- Please note that late fees cannot be added to insurance claims.
- Accounts that are 60 days old will be sent to a collection agency.
- All therapy will be paused and all evaluations and progress reports will not be released until outstanding balances over 30 days old are paid in full.

Cancellation Policy

It is very important for your child to attend their regularly scheduled appointments. These scheduled appointments are part of a recommended treatment plan aimed at improving health, function, and the overall quality of life of your child. Without regular and consistent attendance, the benefits of therapy will be limited or the overall therapy will take longer.

- I understand that I must notify Kidmunicate of all appointment cancelations 24 hours in advance. This will allow Kidmunicate to service other children in need.
- I understand that my account will be assessed a $50 fee for missed appointments because Kidmunicate will need to compensate SLPs for their time. Furthermore, it's not fair to others who may have wanted that time slot.
- This fee will be waived, if the appointment is rescheduled within 3 business days of the original appointment assuming that there are appointments available, which may be the case.
- If you are late for an appointment, the therapy session will still end at the originally scheduled time unless accommodations can be made. If not, you will still be responsible for the full fee.
- Fees for missed appointments / late cancellations cannot be charged to insurance.
- We, of course, will excuse missed appointments due to severe weather conditions.

We understand that families are busy and schedules are often difficult to manage, however, If more than 2 cancellations/no shows occur within a patient's recommended plan of care timeframe, Kidmunicate, LLC holds the right to discontinue therapy services.

Signature	Date

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Consent to Release/Obtain Protected Health Information / Waiver HIPAA Liability

This seeks authorization for the use and/or disclosure of the specific personally identifiable health information set forth made pursuant to the requirements of 45 CFR §164.508, which states the federal privacy regulations of the Health Insurance Privacy and Accountability Act of 1996 and authorizes Kidmunicate, LLC to obtain the personally identifiable health information specifically referenced in this authorization.

- I give my consent to full time, part time therapists and administrators employed by Kidmunicate to use and disclose PHI for treatment of the patient in accordance of the Notice of Privacy Practices.
- I consent to the use and disclosure of the patient's protected health information to the primary care physician/pediatrician (Check box ☐ and _____ initial if you do not want your physician/pediatrician to obtain the information) and any of the healthcare professionals and / or educators listed below. This will be done in accordance of the Notice of Privacy Practices.
- I consent to the use and disclosure of the patient's protected health information for the purposes of obtaining payment for services rendered to the patient by my primary insurance as well as my secondary insurance company in accordance to the Notice of Privacy Practices.

• I have received a copy of the Notice of Privacy Practice and Financial Policy Notice.		

		Y / N	Initial

Name of Additional Professionals	**Specialty** (OT, PT, Educators etc.)	Phone #

Waiver of HIPAA Liability

- Due to federal guidelines protecting all private patient health information, Kidmunicate has a policy in place that prohibits discussion of all information regarding your child's assessment, treatment and care, in public areas such as the patient waiting room. All discussion regarding your child/children should take place in a private room away from the general public.
- By signing this waiver of HIPAA liability, you as the parents or guardians, are 1) agreeing not to initiate a conversation regarding patient health information in a public setting, like our waiting room and 2) releasing Kidmunicate, LLC from any harm or fault caused by discussions of the private health information in open access areas in our facility such as the waiting room or administration office with you as the parent or a preferred guardian you send to accompany your child to their therapy sessions.
- This waiver will be in place from the date signed below, until such a time that you as the parents and/or guardians request in writing to Kidmunicate, LLC that all discussion take place in a private setting.

We encourage ongoing discussion between the therapist and family, so we'll find you a suitable place to talk.

Signature	Date

Patient Information and Consent

Communication Preference

Protecting the privacy of your child and your family is extremely important to us, and HIPAA mandates it. While we prefer to give you updates in person after therapy, there will be times when you will want us to send you written information. The HIPAA privacy rule allows us to communicate with you electronically provided that we apply reasonable safeguards when doing so, including encryption, limiting personally identifiable information like full names, etc. The privacy rule does not prohibit the use of unencrypted email and text for treatment related communications, if the patient or the parent of the patient prefers and requests it. Please understand that if you prefer to receive unencrypted emails and texts, then there is a risk that a third party may be able to obtain that information during transmission or while stored on a computer or phone.

For written progress reports, appointment reminders, updates etc, you have my permission to: (Check all that apply)

- ☐ Send unencrypted emails and I fully understand the risks. (If you do not select this option, we will only send encrypted emails from our HIPAA compliant mail service).
- ☐ Send unencrypted text messages to my mobile phone and I fully understand the risks. (If you do not select this option, we will not send or reply to any text messages.)
- ☐ I prefer encrypted emails
- ☐ I prefer that you send written information via USPS or other mail only.

Signature	Date