It's More Than Speech – Eagle River Clinic
12812 Old Glenn HWY Ste. B2
Eagle River, AK 99577
admin@itsmorethanspeech.com
907-290-9595

It's More Than Speech – Wasilla Clinic
1700 E Bogard Rd. Suite 200A (Bld A)
Wasilla, Alaska 99654
admin@itsmorethanspeech.com
907-290-9595

New Client Checklist

The following documents are required to be completed and returned to our office, before any appointments can be scheduled.

Documents can be emailed to admin@itsmorethanspeech.com or dropped off at either location.

- ☐ Physician Referral -or- Tricare Authorization
- ☐ Child History Intake Form
- ☐ Insurance | Payment | ROI Intake Form – Signed
- ☐ Insurance Worksheet

  Pre-Authorization Required? YES ☐ NO ☐ Request & Provide with Intake Forms
- ☐ Attendance | Rescheduling | No-Show Policy - Signed
- ☐ Driver's License (Please no military ID)
- ☐ Insurance Cards (Front and Back)
- ☐ Previous SLP Evals, IEP's or Outside Reports (If available)
  - ☐ You Received & Reviewed the HIPAA Policy - REVIEW ONLY

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Child Intake History Form

The following information will be used confidentially to complete the speech and language evaluation of your child, make any additional recommendations, and allows the therapist to understand your child's history.

Today's Date: _____ Client Name: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Person completing form: _____
Mailing address: _____

Referring Physician: _____ Has your child received speech therapy in the past?_____

How did you hear about It's More Than Speech? _____

Family Background:

Parent/Guardian 1 Name:_____Phone:_____ ☐ Cell ☐ Home

Email:_____Occupation:_____

Parent/Guardian 2 Name:_____Phone:_____ ☐ Cell ☐ Home

Email:_____Occupation:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Who does the child live with? Check all that apply:

☐ Birth Parent(s) ☐Adoptive Parent(s) ☐ Foster Parent(s)
☐ Grandparent(s) ☐Both Parents ☐ Parent 1 Only
☐ Parent 2 Only ☐Other: _____

Does the child have siblings or are there other siblings in the home?

Child 1 Name:_____ Age:____ Sex:____ Speech Issues:_____
Child 2 Name: _____ Age:____ Sex:____ Speech Issues:_____
Child 3 Name: _____ Age: ____ Sex: ____ Speech Issues:_____
Others:_____

Language(s) are spoken in the home: _____
Who speaks the other language(s)? _____
_____

Describe the child's use/understanding of the language(s): _____

Evaluation:

Briefly describe why you're seeking an evaluation by a speech-language pathologist:

_____

_____

Has the child had a previous speech, language or feeding evaluation / treatment? ☐ Yes ☐ No
By whom: _____ When: _____
Describe the results: _____

_____

Provide previous evaluations, prior to our evaluation. You can contact your provider for a copy.

At what age did you first notice the problem? _____

Is the child aware of or frustrated by their communication difficulties? _____

_____

Medical History:

Mother's Health During Pregnancy:
Was there any infections or illnesses? ☐Yes ☐No
Describe: _____

Child's Health:

1. How many weeks gestation was the child born? _____weeks (40 weeks is typical)
2. The child was _____lbs _____oz and _____inches at birth
3. How was the child delivered? ☐ Vaginally ☐ Cesarean Section
4. Please describe any complications or concerns during labor or delivery:

_____

_____

Check and describe all that apply:

☐ Asthma	Describe: _____
☐ Hearing Tested?	Describe: _____
☐ Brain injury	Describe: _____
☐ Breathing problems	Describe: _____
☐ Behavior problems	Describe: _____
☐ Drug/Alcohol Exposed	Describe: _____
☐ Diabetes	Describe: _____
☐ Ear infections	Describe: _____
☐ Ear tubes	Describe: _____
☐ Frequent colds	Describe: _____
☐ High fever	Describe: _____
☐ Seizures	Describe: _____
☐ Sensory issues	Describe: _____
☐ Sleep issues	Describe: _____
☐ Tongue tie	Describe: _____
☐ Vision Issues	Describe: _____
☐ Tonsillectomy/ Adenoidectomy	Describe: _____
☐ Allergies	Describe: _____
☐ Other:	Describe: _____

Any Diagnoses: _____

Current Medications: _____

Surgical/Medical Treatments: _____

Has the child ever been hospitalized: ☐ Yes ☐ No
Please describe: _____
_____

Does the child currently use any equipment? (Communication device, hearing aids, etc.)
Describe: _____

Is the child currently receiving any of the following services privately or through the school district? If yes, please list the person's name, last date of service and contact information, if available.

- ☐ Developmental Pediatrician _____
- ☐ Neurologist _____
- ☐ PT _____
- ☐ OT _____
- ☐ SLP _____
- ☐ Behavioral Therapist _____
- ☐ Educational Consultant _____
- ☐ Psychologist / Psychologist _____
- ☐ Vision Therapist _____
- ☐ Other: _____

Developmental History:

At what age did the child do the following:
Sit alone: _____ Crawl: _____ Stood Up: _____ Walk: _____
First Word: _____ Combined Words: _____ Sentences: _____
Fed Self: _____ Understood by Others: _____ Toilet Trained: _____

If under 4 years of age, how many words does the child say:
☐ 0-20 ☐ 21-50 ☐51-100 ☐101-150 ☐151-300 ☐ 301-500 ☐ 501+

Does the child produce sentences of the following length?
☐2 words ☐3 words ☐4 words ☐5+ words

What percentage of the child's speech do you understand? _____%
How well do people outside of the family understand their speech? _____%

If the child is not using words, how do they communicate? _____
_____

Does the child have any difficulty with the following?

- ☐ Attention/overly active
- ☐ Aggression
- ☐ Repeats rather than answers questions
- ☐ Understanding people
- ☐ Tantrums
- ☐ Anger
- ☐ Answering – with questions
- ☐ Following directions

☐ Excessive drooling
☐ Producing speech sounds
☐ Trouble making/keeping friends
☐ Remembering
☐ Transition poorly
☐ Choke on liquids
☐ Avoid foods
☐ Mouth objects
☐ Sensitive to noise
☐ Stuttering
☐ School work
☐ Maintaining eye contact
☐ Word Retrieval
☐ Choke on foods
☐ Maintain a special diet
☐ Other difficulties: _____

Please describe any of the above: _____

_____

Educational History:

Is the child currently enrolled in daycare / school: ☐ Yes ☐ No

Name of special program? _____

What day(s) do they attend? _____

What is their grade level? _____

If they are on an IEP or receive any accommodations, please describe: _____

_____

Please provide a copy of the IEP

Please describe any educational difficulties or learning challenges that this child has faced: _____

_____

Social History:

Describe how the child interacts with parents, siblings, or other family members:_____

_____

Describe how the child interacts with other children: _____

_____

What are the child's favorite activities? _____

_____

Does the child participate in any community activities (ex. play groups, sports, etc.) and how is their communication / behavior? _____

_____

Does the child become easily frustrated with certain activities? If so, please explain:_____

_____

Thank you very much for supplying this information!

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Insurance Information | Responsibility of Payment Agreement
Release of Information Authorization

Client (Child) Name:_____ Client DOB: _____

Primary Insurance: _____ Effective Date: _____

Tricare: _____Prime _____Select

***COPY OF INSURANCE CARDS AND DRIVER'S LICENSE REQUIRED.**

Member Name: _____ Member SSN: _____

Member ID #: _____ Group Number: _____

Member DOB: _____ Physician: _____

***Secondary Insurance** (if applicable): _____ Effective date: _____

Member Name: _____ Member SSN: _____

Member ID #: _____ Member DOB: _____

CONSENT FOR SERVICES

_____(Initial) I authorize It's More Than Speech (IMTS) to render appropriate evaluation and therapy services to the client named above in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by IMTS in writing. In addition, IMTS may terminate services by notifying me in writing.

PRIVACY PRACTICES

_____(Initial) I have been provided access to read IMTS Notice of Privacy Practices (HIPAA).

_____ (Initial) I understand that there may be observers present in the clinic. I also understand that no personal information will be given out about my child, except that the observer may hear my child's first name during a treatment session.

_____(Initial) If an intern or volunteer is brought into IMTS to further their education in the field, family will be notified and have the opportunity to accept or refuse the student's involvement.

COMMUNICATION PREFERENCE

Please initial the appropriate lines below:

___I do wish to communicate via email Email address: _____

___I do wish to communicate via Text/Cell Phone Cell phone number:_____

If there are any locations you **DO NOT WANT** messages left, please specify: _____

_____(initial) I understand that IMTS uses electronic medical records with WebPT, and Spectrum Medical Billing to assist in record keeping, delivering services and billing. I consent to allowing my child's medical records, evaluations, notes and other items that pertain to this treatment to be shared with these electronic medical services as needed.

ATTENDANCE / RESCHEDULING / NO-SHOW POLICY

_____(Initial) I understand that my child has a standing appointment for therapy services. **His/her attendance is expected on the days for which he/she is enrolled and is critical to progress on goals.**

_____(Initial) I understand that I am to give notice of planned absences and that No-Shows or excessive absences can result in termination of services. Sick children happen. If your child has had a fever, been prescribed antibiotics for a bacterial infection, been vomiting or having diarrhea in the last 24 hours, please cancel.

_____(Initial) I understand that speech therapy appointments are generally scheduled back-to-back. You are invited to be a part of the session to learn techniques you can use at home; however, if you run an errand, **you must be back within 10 minutes of the end of the session** to review therapy and assure that a late pick-up and affecting the next client does not occur.

_____(Initial) I understand there is an **Attendance, Rescheduling & No-Show Policy**. **One No-Show will be allowed before a $50 charge will be applied per No-Show occurrence.** This amount will not be sent to your insurance, but directly to you for payment.

_____(Initial) I have been provided and have read the full IMTS **Attendance, Rescheduling & No-Show Policy.**

RESPONSIBILITY FOR PAYMENT | AUTHORIZATION TO BILL INSURANCE

_____(Initial) PAYMENT: If insurance will not be filed, an individual payment plan will be required before the start of treatment. IMTS has agreed to file insurance claims for my family. However, the balance is my responsibility whether my insurance company pays or not. ***Payment is due upon receipt of a monthly statement.**

_____(Initial) I authorize IMTS to release any information required by my insurance company for the processing of all medical claims filed on my child's behalf.

_____(Initial) I authorize my insurance company to pay benefits directly to IMTS, for claims filed on my child's behalf.

Evaluation Charges: $500 Individual Treatment: $185

_____(Initial) I understand that IMTS is a preferred provider for Alaska Medicaid, Tricare, BCBS, Cigna and Aetna. Charges not covered by my private insurance company are my own responsibility to pay.

_____(Initial) I understand that I may be asked to assist IMTS in having claims processed by my private insurance company. If my private insurance company has not processed a claim within 30 days of submission by IMTS, I will be required to call my insurance company to aide in the processing of the claim(s).

_____(Initial) I understand that all accounts are to be paid upon receipt of a statement. I understand that if this account carries an outstanding balance for 30 days, my child's appointment's will be suspended until the balance is paid.

_____(Initial) I understand that if my account carries an outstanding balance for 90 days, my account will be turned over to a collection agency. I am responsible for all charges encountered in the collection process. Returned checks will be subject to a $25 returned check fee.

_____(Initial) **I understand that I cannot see another private speech provider on the same day**, because insurance will not pay for the same services on the same day. If I am seeing additional speech therapists, I will inform IMTS before the days of service and will request changes to the schedule to avoid payment issues. If I neglect to do so and services are not covered by insurance, I take full responsibility for payment of service.

AUTHORIZATION TO EXCHANGE , OBTAIN OR RELEASE OF INFORMATION

For the reasons identified in this form, I _____(client or family member) hereby grant IMTS permission to communicate (exchange, obtain, or release) my medical information with the locations/persons listed: (example: ASD, Playful Learning, ABA, Additional Physicians).

_____

_____

Information to Be Released or Received:

- ☐ Medical History
- ☐ Therapy Evaluation
  - ☐ SLP ☐ OT ☐ PT ☐ Other: _____
- ☐ Treatment Notes
  - ☐ SLP ☐ OT ☐ PT ☐ Other: _____
- ☐ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of: (check all that apply)

- ☐ Coordinating care with other professionals
- ☐ Providing continuity of services
- ☐ Updating therapeutic progress or information for billing purposes
- ☐ If Medicaid, waivers or other services that require progress notes
- ☐ I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.

_____(Initial) I understand that this authorization will remain valid until written revocation of this authorization is presented.

_____(Initial) I understand that if I assign another adult or care provider to transport my child, I allow the therapist to review session with that individual.

_____ _____
Print Name of Client Date

_____ _____
Signature of Participant or Legal Representative Relationship to Client

GENERAL ACKNOWLEDGEMENT OF FORMS

My initials above signify that I have read and understand each of the above policies. I have been given the opportunity to ask questions and clarify any of the above. My signature further signifies my agreement and understanding.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

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How to Determine Your Insurance Benefits for Speech Therapy

1. Call your insurance company. The # for customer service is on your insurance card. Select the option that will allow you to speak with a customer service provider, not an automated system.

2. Ask the customer service provider to quote your Speech Therapy benefits in general. These are frequently termed rehabilitation benefits and can include physical therapy, occupational therapy, speech therapy, and sometimes chiropractic.

   You may need to ask for a specific CPT codes:
   92523 for Speech Evaluation
   92507 for Speech Therapy

Client Name: _____ * Form not required for Tricare

What YOU need to know:

- Name of customer service rep you are talking to:_____
- Call Reference Number_____
- Do you have a deductible?_____If so, how much is it?_____How much is already met?_____
- What percentage of reimbursement / owe do you have? (60/40%, 80/20%, 90/10%, are all common) _____
- **OR** what co-pay do you have? ($25, $50 are all common) _____
- Does your policy require pre-authorization on file for speech therapy services? YES NO
  - **IF YOUR POLICY REQUIRES PRE-AUTHOIZATION:** Request it and provide with intake forms.

    Insurance companies that usually require pre-authorization: CIGNA, GEHA, EBMS, WEPTPA, UHC & Some BCBS Market Place Plans.

- Is there a visit limit per year?_____(Limits are combined with OT & PT)_____

What this information means:

- A deductible must be satisfied before the insurance company will pay for therapy treatment. You may owe more money to satisfy the deductible.

- The reimbursement percentage will be based on your insurance company' established "reasonable and customary/fair price" for the service codes rendered. This price will not always match the charges billed.

This worksheet was created to assist you in understanding your therapy services and is not a guarantee that the insurance company will pay. It's More Than Speech, is a preferred provider for Alaska Medicaid, Tricare, BCBS, Cigna and Aetna. Charges not covered by my private insurance company are my own responsibility to pay.

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ATTENDANCE / RESCHEDULING / NO-SHOW POLICY

It's More Than Speech (IMTS) is committed to providing quality treatment for children and their families. To maximize your child's potential in therapy and be fair to the number of children on our waiting list, it is imperative that we adhere to our attendance policy. The following guidelines have been established to ensure the best services for your child and our community:

1. Therapy appointment times will be arranged by our office staff. We will be as accommodating as possible when arranging treatment times.
2. IMTS understands that emergencies may arise that warrant appointment rescheduling. It is our policy that our staff will make every effort to provide timely rescheduling and we ask that you make every effort to **reschedule your appointment no less than 24 hours in advance.** This will enable IMTS to plan services for the day or offer the open appointment to another child on our wait list who is needing services. **You can contact the office to reschedule at 907-290-9595.**
3. In order to maintain consistency in therapy services, have your calendar available to reschedule for the next opening.
4. **If your child fails to attend a scheduled appointment without reasonable effort being made to inform IMTS of a need to reschedule within 24 hours, IMTS will consider this a "No-Show".** The therapist will be available for fifteen minutes beyond the start of the appointment time before declaring a "No-Show".
5. **One "No-Show" will be allowed before a $50 charge will be applied per occurrence.** This amount will not be sent to your insurance, but directly to you for payment. Our team works to be prepared for you and there are many kids needing services.
6. **Three "No-Shows" within an eight-week period**, your child will be moved to our flex schedule, and we will contact you when we have openings.
7. **Two "No-Show" appointments in a row** will result in the discharge your child and notification of your referring physician.
8. **Frequent cancellations** that are not the result of illness, will also cause you to be discharged, placed on our flex schedule or waiting list.
9. **Frequent illnesses that result in multiple missed sessions** will interfere with your child's progress and services may be paused until they are well enough to attend regularly.

We understand that circumstances may prevent you from being able to take advantage of the therapy services for which your child has been referred, or the services we provide are not meeting your family's needs. If this happens, please inform IMTS that you would like to discontinue services at admin@itsmorethanspeech.com or by calling the clinic at 907-290-9595.

Acknowledgment of Attendance / Rescheduling / No-Show Policy

I acknowledge receipt of It's More Than Speech Attendance / Rescheduling / No-Show Policy and understand the importance of consistent attendance in order to remain on our schedule and continue to receive therapy services.

_____ _____
Signature Date

_____ _____
Printed Name Relationship

_____ _____
IMTS Representative Date

Referring Physician: _____

HIPAA POLICY
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) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. 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. 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.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

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 be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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 the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, 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 reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775