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

Insurance Information

Patient Name: ______________________________ Patient DOB: ________

Primary Insurance: _____________________________Effective Date:

COPY OF INSURANCE CARD AND DRIVER'S LICENSE NEEDED. CAN BE TAKEN AT THE OFFICE IF YOU CANNOT SCAN IN.

Member Name: _______________________ Member SSN: _______________

Member ID #: _________________________ Group Number: ____________

Member DOB: ______________ Physician: _________________

Is pre-authorization required? _______ Co-Pay Amount: $ ________

Deductible: Individual: $_______ Family: $ __________

Progress Towards Deductible to Date: $ ____________

Secondary Ins. (if applicable): _______________________ Effective date:

COPY OF INSURANCE CARD AND DRIVER'S LICENSE NEEDED. CAN BE TAKEN AT THE OFFICE WHEN PAPERWORK TURNED IN.

Member Name: _______________________ Member SSN: _______________

Member ID #: _________________________ Member DOB: ______________

Is pre-authorization required? _______ Co-Pay Amount: $________

Deductible: Individual: $_______ Family: $ __________

Progress Towards Deductible to Date: $____________

Consent for Services

____ (Initial) I authorize "It's More Than Speech" to render appropriate evaluation and therapy services to the client named below 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 "It's More Than Speech" in writing. In addition, "It's More Than Speech" may terminate services by notifying me in writing.

Privacy Practices

_____ (Initial) I have been provided a copy of "It's More Than Speech's" Notice of Privacy Practices.

_____ (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 "It's More Than Speech" 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 let us know what methods are best for receiving messages, responses, appointment reminders, etc. You may check more than one:

Home Phone: _____ Cell: _____ E-mail: _____ Text: _____

_____ You are authorizing messages via phone, email or text. If there are any locations you do not want messages left, please specify: _________________

_____ (initial) I understand that "It's More Than Speech" uses electronic medical records with Webpt, Theraplatform for Telehealth 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/Cancellation 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 critical to progress on goals.

_____ (Initial) I understand that I am to give notice of planned absences and that no-shows or excessive absences could 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. Generally, runny noses, being tired and grumpy are not reasons to stay home; however, in light of COVID19, be extra cautious if there has been illness in your family. We will begin taking temperatures at this time when children arrive and follow the changing mandates as recommended for this type of facility.

______ (Initial) I understand that speech therapy appointments are generally scheduled back-to-back. You are invited to be a part of the session so as 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. Thank you for understanding.

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. It's More Than Speech 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 an invoice.**

_____ (Initial) I authorize It's More Than Speech 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 It's More Than Speech and Andrea Toth, M.A., CCC-SLP, for claims filed on my child's behalf.

Evaluation Charges:	$425
Individual Treatment:	$175
Group Sessions:	$ 49

_____ (Initial) I understand that 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.

_____ (Initial) I understand that I may be asked to assist It's More Than Speech 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 It's More Than Speech, 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 an invoice. I understand that if this account carries an outstanding balance for 30 days, my child's appointment will be suspended until the balance is paid. I also understand that if my account is turned over to a collection agency, I will be 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 as insurance will not pay for the same services on the same day. If I am seeing additional therapists, I will inform It's More Than Speech of the days of service and any changes to the schedule to avoid payment issues. If I neglect to do so and services are not covered by insurance, I take responsibility for payment of service.

Authorization to Exchange, Obtain or Release Information

For the reasons identified in this form, I ___________________________ (client or family member) hereby grant "It's More Than Speech" permission to communicate (exchange, obtain, or release) my medical information with the locations/persons listed:

____

____

____

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.)**

Family members authorized to receive information:

Name: _________________________ **Relation:** __________________
Name: _________________________ **Relation:** __________________

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.**

☐ **I understand that this authorization will remain valid until written revocation of this authorization is presented.**

______________________________ _____________________
Print Name of Client Date
______________________________ _____________________
Signature of Participant or Legal Representative Relationship to Client

General Acknowledgement of Forms

My initials 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

____
Client Date of Birth

______________________________ _____________________
Signature of Client or Legal Representative Relationship to Client