

Welcome to Harbor Speech Pathology! We are happy to assist you with any questions you may have. Please take a few moments to read the following information.

**Insurance:** We accept most major insurance plans. As a courtesy to you, we will call your insurance company to verify your coverage for therapy in our office. Benefits quoted by an insurance representative are not a guarantee of payment and at times, can be quoted incorrectly. We encourage you to call your insurance company prior to your first appointment to verify that you are covered for therapy in our office.

**Evaluation:** Depending on age and abilities, we spend between 30 minutes and 1 hour with patients for the first appointment to determine the treatment plan and present levels of functioning. The evaluation generally involves a detailed intake, a speech and language, cognitive, voice or swallow assessment, goals and objectives to target if needed. Please understand that the unpaid balance is your responsibility.

**Treatment:** We are able to accommodate our patients with appointments times from 9:00 a.m. to 5:00 p.m., Monday through Thursday. We do our best to find a regular appointment time (weekly or bi-weekly, if desired) for each patient with one of our therapists.

**Cost of Supplies:** Occasionally, with your consent, we will order supplies to be used in your therapy sessions and at home. In the case that your insurance company does not cover these expenses, you will be responsible for the bill.

**Financial Policy:** Insurance co-pays are due at time of service. It is the policy of our office to bill all claims to your insurance company as a courtesy to you. The responsibility for payment of your account remains with you at all times, including closed or rejected Labor and Industries claims.

**Your insurance policy is a contract between you and the insurance company.** In many instances your insurance will cover only a portion of the charges. You should be aware that you are responsible for the balance of your bill. If your claim is denied, you will be responsible for the entire charge. If no insurance is available, private payment is due at the time of service. We accept personal checks, all major credit cards, and cash payments.

**Referrals/Prescriptions:** It is Harbor Speech Pathology's policy to have a referral or prescription on file for all patients, regardless of your insurance company's requirements. It is your responsibility to obtain one from your primary care physician and make sure we have it at the time of service.

I HEREBY AGREE TO FULL RESPONSIBILITY FOR ALL EXPENSES INCURRED BY OR IN THE ACCOUNT OF

\_\_\_\_\_.

I AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO HARBOR SPEECH PATHOLOGY FOR SERVICES RENDERED. I AGREE THAT I WILL PAY ANY REMAINING BALANCE NO LATER THAN 30 DAYS FOLLOWING THE INSURANCE PAYMENT.

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date

## WAIVER AND RELEASE - DRIVEABLE ASSESSMENT

I acknowledge and understand that the DriveABLE assessment procedures are intended to be used for the evaluation of experienced drivers whose current competence to drive an automobile is questionable due to a medical condition, medication or other condition which may have a chronic and compromising effect on mental and/or cognitive abilities. It is not intended for novice drivers, competence determinations regarding any vehicle other than an unattached automobile, nor is the evaluation intended for clients for whom the basis for questioning competence is the presence of an illness with sporadic compromising episodes.

I acknowledge and understand that neither the DriveABLE evaluation procedures nor any other procedures can guarantee that a person will drive safely or be free of vehicle crashes. Performance resulting in any score indicates only that the client has a greater or lesser probability of performing the type or number/severity of driving errors during a specialized on-road evaluation that are characteristic of a population of drivers who, as a group, are unsafe drivers because of a medical condition(s) and/or medication(s) that has compromised mental abilities. No other claim is made or implied. The client may have poor driving habits, which, if ameliorated, could improve driving safety. If the client has a progressive illness, acquires one or more new illnesses or changes medications, competence may change. In such cases, the outcome of the current evaluation may no longer be valid and re-evaluation would be warranted.

I understand and acknowledge that the enclosed report is prepared exclusively for the Addressee of the Report and further that DriveABLE Assessment Centres Inc. and its subsidiaries, its employees, officers, directors and agents assume no liability for or responsibility for any loss or damage suffered or incurred by any person arising from or in any way connected with the use of or reliance upon the information contained in the Report, including without limitation, any liability for loss or damage arising from the negligence of DriveABLE™, its employees, officers, directors, and agents in any way connected with the information contained in the Report. Regardless of recommendations in the Report, DriveABLE™ in no way warrants or guarantees that a client will not operate a motor vehicle in a negligent manner.

I understand and acknowledge that DriveABLE Assessment Centres Inc. makes recommendations based on the performance on the DriveABLE assessment procedures and in no way makes, controls or legislates driver licensing decisions and further does not control the reporting or recommendations made by recipients of the report or the reliance or extent to which the results may have affected those decisions.

I intend by this Waiver and Release to release, in advance, and to waive my rights and discharge all of the persons and entities mentioned above, from any and all claims for damages for death, financial loss, personal injury or property damage which I may have, or which may hereafter accrue to me as a result of the report and contents thereof prepared through the DriveABLE assessment procedures, even though this liability may arise from negligence or carelessness on the part of the persons or entities being released, or because of their possible liability without fault, as the legal term "fault" is defined by statute, common law or court precedent. I understand and agree that this Waiver and Release is binding on my heirs, assigns, and legal representatives.

Should any portion of this Waiver and Release be judicially determined invalid, voidable or unenforceable, for any reason, such portion of this Waiver and Release shall be severable from the remaining portions herein and the invalidity, voidability, or unenforceability thereof shall not affect the validity, effect, enforceability, or interpretation of the remaining provisions of this Waiver and Release.

I have carefully read this Waiver and Release and fully understand its contents. If I have been appointed a legal guardian through a power of attorney they have completely reviewed this Waiver and Release, understand and consent to its terms, and authorize my participation by his/her signature below. I am aware that this is a RELEASE OF LIABILITY and a fully enforceable contract between me and the persons and entities mentioned above and I sign of my own free will.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature, if applicable, of the person legally appointed as guardian to the participant.

Signature of Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

PRINTED NAME OF PERSON SIGNING ABOVE: \_\_\_\_\_

# Adult Admission Form

TODAY'S DATE: \_\_\_\_\_

## PATIENT INFORMATION:

Social Security Number: \_\_\_\_\_ Sex:  Male  Female  
Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ Other/Cell Phone: \_\_\_\_\_  
Reminder Call Preference:  Home Phone  Cell Phone  
E-Mail Address: \_\_\_\_\_ Marital  
Status:  Single -  Married -  Separated -  Divorced -  Widowed \_\_\_\_\_  
Employment Status:  Full Time -  Part Time -  Not Employed -  Retired  
Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Parent/Guardian (if under 18): \_\_\_\_\_  
Next of Kin Not Living With You: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Referring Physician/Primary Care: \_\_\_\_\_

## Insurance Information: PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD/CARDS

**Primary Insurance:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_  
**Subscriber Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
Relationship to Patient:  Self -  Spouse -  Child SSN: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_  
**Subscriber Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
Relationship to Patient:  Self -  Spouse -  Child

Release of benefits and information: I hereby authorize my insurance benefits be paid directly to the practitioner. I am financially responsible for any balance due. I authorize the practitioner or insurance company to release any information required for any claims. I understand that simple interest will be added to any unpaid balance after 60 days of 1.3%.

Signature of patient or responsible party \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

.....

To Be Completed by Speech-Language Pathologist:

ICD-10: \_\_\_\_\_ CPT: \_\_\_\_\_

## Cancellation Policy

Dear Valued Patient,

We realize that coming to us for treatment requires a substantial investment in time on your part. We have adequate staff on hand to allow 30-60 minutes for each appointment. This does mean that if you cancel an appointment without adequate notice, we may not be able to fill your appointment time. If you arrive late for your appointment you will miss part of your treatment for that day.

We charge a fee of **\$50.00** if an appointment is canceled without 24-hour notice. This charge is NOT covered by insurance and will be your direct responsibility. This is much less than the value of an appointment. It is not intended to be punitive but rather to offset part the cost of having a therapist scheduled.

Thank you for your understanding with this policy as we provide you with quality services.

Sincerely,

Channa Beckman, M.A., CCC-SLP / CBIS  
Harbor Speech Pathology

I have read and understand Harbor Speech Pathology's cancellation policy.

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Signature

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Date

## CONSENT FOR DISCLOSURE WRITTEN AND VERBAL COMMUNICATIONS

I, \_\_\_\_\_, hereby authorize and request Harbor Speech Pathology or its representatives to:

( ) Release information to ( ) Obtain information from ( ) Exchange information with the following individual(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Regarding: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

INFORMATION TO BE RELEASED:	YES	NO
Progress reports	_____	_____
Evaluations of treatment participation	_____	_____
Medical history/Social history	_____	_____
Alcohol and other drug history	_____	_____
Psychological/Psychiatric testing, evaluation and reports	_____	_____
Other (specify) _____	_____	_____
_____		

I understand that my records are protected under the Federal (42CFR) and State (RCW 71.05.390) confidentiality Law and Regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically as specified below or in 90 days without such specification. This information released may be obtained via mail, telephone, fax, or in person.

Specification of the date, event, or condition upon which this consent expires: \_\_\_\_\_

\_\_\_\_\_  
PATIENT/ GUARDIAN SIGNIFICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

## PATIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA AUTHORIZATION)

### HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT YOUR PRIVACY RIGHTS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Harbor Speech Pathology, P.S.** is dedicated to ensuring the privacy of your records. In serving our patients, we create records regarding treatment and services that are provided in order to have accurate information and ensure the appropriateness and efficiency of treatment services. Federal law requires us to strictly protect any personally identifying information of our patients. This notice discloses our policies regarding the storage, use, and sharing of confidential patient information. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

**Harbor Speech Pathology, P.S.** is required by law to keep your health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history
- Your test results
- Treatment notes
- Insurance information

A government rule requires that you get a copy of this privacy notice. This rule is called the Health Insurance Portability and Accountability Act, or HIPAA for short. We will ask you to sign a paper acknowledging that you have been given this notice.

#### **Your Health Information May Be Used or Shared without your permission for the following reasons:**

1. **Treatment:** We may share your information with doctors or other health care providers who care for you. For example, if your doctor orders speech therapy, we may share the results of our treatment with that doctor.
2. **Payment:** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for therapy services. This may include sharing important medical information. We may share information to:
  - Get the insurance company's permission to start treatment
  - Get permission for more treatment
  - Get paid for the treatment you receive
3. **Health Care Operations:** We may use and share your health information to run the clinic and make sure all patients receive good care. For example, we may use your health information to:
  - See how well our services are working
  - See how well our staff is doing
  - See how we compare to other clinics and private practices
  - Make our services better
  - Help others study health care services

#### **Your health information may also be used or shared without your permission for:**

- **Abuse and Neglect:** We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders:** We will use your information to remind you of upcoming appointments. If you wish to get text message reminders, please ask the front desk.
- **As Required by Law:** We will share your information when we are told to by federal, state or local law. We will also share information if we are asked by the police or courts.
- **Government Functions:** Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- **Information About a Person Who Has Died:** We may share information with the coroner, medical examiner, or a funeral director, as needed.
- **Health-Related Benefits and Services:** We may use your information to let you know of other services that might be of interest to you.
- **Public Health Risks:** We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
- **Regulatory Oversight:** We may use or share your information to report to agencies overseeing health care. This may include sharing information for audits, licensure and inspections.
- **Threats to Health and Safety:** Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others.

## PATIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA AUTHORIZATION)

**Worker's Compensation:** We will share your information with Worker's Compensation if your case is being considered as a work-related injury.

### When Your Permission is Needed to Use or Share Your Health Information

You must give us your permission to use or share your health information for any situation that is not listed on this notice. You will be asked to sign a form to allow us to share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

### Your Privacy Rights You have the right to:

- **Ask us not to share your information:** You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately:** You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call you but not email. Or you may want us to call you at work and not at home. You must ask in writing.
- **Look at and copy your health information:** You have the right to see your health information and get a copy of that information at any time. You have the right to see treatment, medical and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
- **Ask for changes to your health information:** You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your information was used or shared:** You can ask us to tell you when your information was shared and whom we shared it with. There are some rules about this:
  - You need to ask us in writing.
  - You must tell us the dates you are asking about and if you want a paper or electronic copy.
  - You may get information going back six (6) years, but it cannot be for earlier than April 14, 2003. This is the date when the government privacy rules took effect.
- **Get a paper copy of this privacy notice:** You can get a paper copy of this notice at any time.
- **File complaints:** You can file a complaint with us or with the government if you think that
  - Your information was used or shared in a way that is not allowed
  - You were not allowed to look at or copy your information
  - Any of your rights were denied

### Who is Covered by This Notice

The people that must follow the rules of this notice are:

- All speech-language pathologists at **Harbor Speech Pathology, P.S.**
- Anyone who is allowed to add health information to your file.
- Any volunteers who may help you while you are at this clinic.

### Changes to the Information in This Notice

We may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

### Complaints

You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. All complaints must be in writing. You will not get in trouble for filing a complaint.

If you have any other questions about this notice or your privacy rights, please ask our office staff.

**I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES DISCLOSED IN THIS NOTICE.**

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Patients Name

Patient/ Legal Guardian Signature

Date

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  - Get the insurance company's permission to start treatment
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  - Get paid for the treatment you receive
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  - See how well our services are working
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  - See how we compare to other clinics and private practices
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- **As Required by Law:** We will share your information when we are told to by federal, state or local law. We will also share information if we are asked by the police or courts.
- **Government Functions:** Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
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- **Ask us to contact you privately:** You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call you but not email. Or you may want us to call you at work and not at home. You must ask in writing.
- **Look at and copy your health information:** You have the right to see your health information and get a copy of that information at any time. You have the right to see treatment, medical and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
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