Trinity Speech, Language and Learning Center, Inc.

Child's Full Name:_____ Sex:_____

Address:_____

Home #:_____ Cell #:_____ Work #:_____

Age:____ Date Of Birth:_____ School: _____Grade:__

Name of Responsible Party:_____

(Please circle: Father, Mother, Guardian, Grandparent, other)

Address:_____

Contact Phone Number: Home: _____Cell:_____

Employer:_____ Work#:_____

Insurance Company:_____ Contract#_____

Group#_____ Insured's Name on Card:_____

Insured's Employer:_____ Insured's DOB:_____

Secondary Insurance: Yes or No

Child's primary care physician:_____

Is your child currently receiving speech therapy at school: Yes No

AUTHORIZATION FOR SERVICES AND TREATMENT

I, the undersigned responsible party, have a child at Trinity Speech, Language and Learning Center, Inc.; hereby authorize this clinic to administer services considered necessary based on the findings of the certified and licensed speech language pathologist. I understand that no guarantee has been (or will be) made to me as a result of the speech therapy treatment. I hereby certify that I have read and fully understand this Authorization of Speech Services and Treatment.

AUTHORIZATION MUST BE SIGNED BEFORE TREATMENT

Signature of Parent / Guardian / Relative_____
Date:_____

CONCERNING INSURANCE

All professional services are charges to the client. Necessary forms will be submitted to your insurance carrier based on the information you have furnished. We will submit claim forms to your insurance carrier with which you are enrolled for benefits. The responsible party (parent / guardian) is responsible for all fees, regardless of insurance coverage.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Trinity Speech, Language & Learning Center, Inc. to furnish the insurance carrier concerning treatment. I hereby assign Trinity Speech, Language and Learning Center, Inc. all payments for services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by insurance. I agree to pay the difference or the entire balance, if necessary.

Insured Signature:_____ Date:_____
Insured or Responsible Party

I hereby acknowledge that I have received the "Privacy Practices Notice" For Trinity Speech, Language and Learning Center, Inc.
Signature:_____ Date:_____

Trinity Speech, Language, and Learning Center Inc.

Patient Confidentiality Release Form

Patient Name:_____

Due to patient confidentiality issues, it is necessary that we have your permission to release any information regarding your child's office visits, or any other information pertaining to his/her speech treatments. Please list any family member, or school officials that you give us permission to discuss your child's speech treatment with.

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

Parents Signature:_____ Date:_____

TRINITY SPEECH, LANGUAGE AND LEARNING CENTER
474 TARRANT ROAD
GARDENDALE, AL 35071

NOTICE RELATED TO INSURANCE CLAIMS

The ***Trinity Speech, Language & Learning Center*** accepts different types of health insurance in instances where an appropriate diagnosis has been determined, and the client's health plan covers the applicable services. As with other clinical practices, ***TSLLC*** files a client's claim with their health plan as a service. **The client remains responsible for the cost involved with the service provided by the *Trinity Speech, Language & Learning Center.***

There is great variability among health plans, and the services they cover. It is the client's responsibility to understand the nature of their coverage. In fact, this type of information is not given to a service provider until they are given the access information by the insured. The ***TSLLC*** will discuss a client's coverage when asked for input, but ultimately we cannot be held responsible for an insured client's understanding of their health plan.

When a potential client contacts the center, it is our policy to instruct the caller to contact their insurance provider to determine whether insurance coverage is possible. Representatives for the client's health insurance plan are trained to explain the benefits accordingly. However, in some cases, it may seem like coverage is possible, but **decisions may be deferred until a diagnosis is determined.**

In all cases, the diagnosis determines whether coverage is applicable. Clients are hereby informed, they remain responsible for any cost not covered by their insurance plan. ***TSLLC*** cannot be held responsible for the variations among individuals' health coverage plans. Clients are responsible for all charges incurred at the ***TSLLC.***

Please remember clients who have insurance coverage, entered into an agreement with the insurance provider regarding payment for the health care the client requires in the course of the year. The Trinity Speech, Language & Learning Center is not responsible to make the insurance company pay for the claim. ***TSLLC*** files claims according to legitimate professional protocols as a health care provider. ***TSLLC*** makes

every effort to receive payment for legitimate services covered under the individual's plan. **If a problem occurs, the individual who sought the services at the Trinity Speech, Language & Learning Center is responsible for the charges involved.**

We appreciate the opportunity to serve our clients and their families. Please consider the coverage and cost applicable to treatment at the clinic. We want to be fair about these matters, but cannot be held responsible for matters outside of our control.

Thank you

Trinity Speech, Language & Learning C enter

AGREEMENT TO PAYMENT TERMS

I have carefully read and understood the issues covered in this notice related to insurance coverage. I understand it is my obligation to pay for the cost of all services provided by the Trinity Speech, Language & Learning Center. In some cases, that may be handled through my insurance plan, and in other instances I may need to pay for those services directly.

I understand I am responsible for all deductibles, co-payment charges, and any billed service not covered by my insurance plan. Therefore, I agree to pay all bills associated with services administered by the staff at the Trinity Speech, Language and Learning Center. I submit my signature below as an agreement to these conditions.

_____

Parent, Caregiver, Client signature

_____

Date

Acknowledgement of Receipt of Notices of Privacy Practices
For
Trinity Speech, Language, and Learning Center Inc.

Patient Name:_____

Date of Birth:_____

By signing below, I acknowledge that I have received a copy of the **Notice of Privacy Practices** from:

Trinity Speech, Language, and Learning Center Inc.
474 Tarrant Road
Gardendale, AL 35071
205-608-2999

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Notice of Privacy Practices

The policy of Trinity Speech, Language and Learning Center is to protect the confidentiality, integrity and security of the protected health and personal information of our clients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to clients who are current or future information that Trinity Speech, Language and Learning Center receives from you as our client.

As well as, individually identifiable health and personal information or any information obtained by Trinity Speech, Language and Learning Center in connection with providing healthcare treatment, obtaining payment and related health care operations. This related to past, present or future information that Trinity Speech, Language and Learning Center receives from you as our client.

Trinity Speech, Language and Learning Center collect personal information in order to learn about your medical history, medical conditions render treatment and collect payments for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow up and appointments reminders, as well as treatment alternatives or other health-related benefits. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to efficiently coordinate your treatment plan. For contracted insurers, your information will be used for claims management and to obtain payment from you insurance carrier. As required by your insurance contractor, we will exchange data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification and utilization review.

Your information is maintained in our office in our computer system.
We also maintain information about you in your medical chart. Trinity Speech, Language and Learning Center limit's the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.
We do not disclose personal information to third parties unless one of the Following exceptions applies:

* We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to

whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to Trinity Speech, Language and Learning Center.

* Federal, state or other applicable law requires us to share protected Information or records.

We are obligated to abide by the terms of this notice. If at any time in future, it is necessary to disclose any of your personal information in a way that is materially different from this policy, Trinity Speech, Language and Learning Center will give you notice of the change through a mailed announcement or on your visit following the change.

With some exceptions, you have the right to review and obtain a copy of your health information. This request must be in writing and there will be a reasonable charge to provide you with a copy of your information. You also have the rights to request your records to be amended, to request special accommodations and restrictions of your health information and receive an accounting of the disclosures of your information. You have the right to request to receive confidential communications of your information. Trinity Speech, Language and Learning are not obligated to agree to a requested restriction. We must receive a written request from you to administer these rights. If you have a complaint about the management of your health information or believe your privacy rights have been violated, contact Trinity Speech, Language and Learning Center (205-608-2999). You have the right to file a complaint with the Secretary of the Department of Health and Human
Services if you believe that your privacy rights have been violated there will be no retaliation for filing a complaint.