Speech & Play LLC
Tel: (503) 946-5375
Fax: (503) 626-0663
connect@speechandplay.com
www.speechandplay.com

Speech & Play Policies

CANCELLATIONS AND NO-SHOWS: Appointments canceled with less than 24 business-hours notice will be subject to a fee of $55.00, which is not reimbursable by insurance, and will be automatically charged to the credit card provided. If you have a Monday appointment but cancel after our office closes on Friday, this will be considered a late cancellation. Fee will be waived if cancellation is due to illness or emergency. ☐ (Initials)

FINANCIAL RESPONSIBILITY: You are responsible to know your insurance benefits, and you are ultimately financially responsible for all services rendered. We will bill the listed insurance companies when you provide us with current, complete information. By signing below, you agree you are responsible to pay for all services denied and for amounts not paid under this assignment, including your health insurance deductible and coinsurance/copays. Even though an insurance claim may be pending, you may receive a statement if your account has an outstanding balance. Speech & Play, LLC cannot accept responsibility to collect your insurance claim or to negotiate a settlement on a disputed claim. You are responsible for the timely payment of your account. If after multiple attempts to reach you and you have taken no action to pay your bill, your overdue balance may be sent to collections. If your account is deferred to a collection agency, you agree to pay all collection costs incurred. We reserve the right to terminate services should your account balance not be in alignment with this policy. ☐

PAYMENT DUE AT TIME OF SERVICE: “I understand that payment of deductible, co-payment or co-insurance is due at the time of service.” We will collect your copay/coinsurance on the day of each visit. Please note we have a return check fee of $35 dollars. An account statement will be posted to your client portal monthly if a balance is due. Please note the amount collected in the office may only be a portion of your balance. Actual patient responsibility can only be determined once your insurance company has processed a claim. If you have further financial obligation, a statement will be posted to your client portal to be paid in full within 30 days. ☐

You can approve Speech & Play, LLC to keep a credit card on file to process copayments, address outstanding balances, and for your convenience. Speech & Play stores credit card information securely and will automatically charge co-payments/co-insurances to the card on file following sessions. Balances older than 30 days will also be charged to the card on file. If you have questions regarding your balance, please call our office as soon as possible. ☐

ASSIGNMENT OF BENEFITS: I understand and authorize the release of medical information to file health insurance claims for me by Speech & Play, LLC. I also authorize my insurance provider(s) to pay Speech & Play, LLC directly. ☐

I have read and understand the above information and I understand my responsibility for the payment of my account.

Patient Signature: _____ **Date:** _____

Speech & Play LLC
Tel: (503) 946-5375
Fax: (503) 626-0663
connect@speechandplay.com
www.speechandplay.com

This notice describes how medical information about you and your child may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may use medical information about you or your child in order to provide you with medical treatment or services.

Payment: We may use and disclose medical information about you or your child so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party.

Health Care Operations: We may use and disclose health information about you or your child for operations of our health care practice.

Individuals Involved in Your Care or Your Child's Care or Payment for Your Care or Child's Care: We may release medical information about you or your child to a friend or family member who is involved in your medical care or your child's medical care.

Health-Related Services and Treatment Alternatives: We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you.

As Required By Law: We will disclose medical information when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you or your child as required by military command authorities.

Worker's Compensation: We may release medical information about you or your child for workers' compensation or similar programs.

Public Health Risks: We may disclose medical information about you or your child for public health activities.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information in response to a court or administrative order.

Law Enforcement: We may release medical information if asked to do so by law enforcement officials.

Coroners, Medical Examiners, and Funeral Directors: We may release medical information to a coroner or medical examiner.

National Security and Intelligence Activities: We may release medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Speech & Play LLC
Tel: (503) 946-5375
Fax: (503) 626-0663
connect@speechandplay.com
www.speechandplay.com

Protective Services for the President and Others: We may disclose medical information to authorized federal officials so they may provide protection to the President, other authorized persons of foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOU AND YOUR CHILD'S MEDICAL INFORMATION

Your Right to Inspect and Copy: To inspect and copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed.

Your Right to Amend: If you feel that medical information we have about you or your child is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request.

Your Right to an Accounting of Disclosures: You have the right to request in writing, a list of accounting for any disclosures of you or your child's medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you or your child for treatment, payment, or health care operations. We are not required to agree to your request.

Your Right to Request Confidential Communications: You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location.

Your Right to a Paper Copy of This Notice: You have the right to request a paper copy of this notice at any time.

Changes to this Notice: We reserve the right to change this notice at any time.

Complaints: If you believe you or your child's privacy rights have been violated, you may file a complaint with the practice or with the Security of the Department of Health and Human Services.

Other uses of Medical Information: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you or your child, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you or your child for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and your family.

I have read and understand the above information.

Parent Signature: _____ **Date:** _____

Speech & Play LLC
3869 SW Hall Blvd., Beaverton, OR 97005
Tel: (503) 946-5375 / Fax: (503) 626-0663
connect@speechandplay.com
www.speechandplay.com

Release of Information Form

I authorize **Speech & Play, LLC** to receive, disclose and share specific health information described below regarding:

_____ _____

(Name of Client) **(Date of Birth)**

*This information may be received from, disclosed, and shared with:

_____

(Name of Individual or Entity Receiving/Disclosing Information)

_____ _____ _____ _____

(Street Address of Individual Receiving/Disclosing Information) (City) (State) (Zip Code)

_____ _____ _____

(Phone Number) (Fax Number) (Email Address)

*Specific health Information to be disclosed (check all that apply):

☐ Physician Reports ☐ Evaluation Reports ☐ Billing Information ☐ Client Notes

☐ Progress Reports ☐ IEP/IFSP ☐ Other (please specify): _____

*The PURPOSE of the disclosure is: ☐ Continued Care ☐ Legal ☐ Disability ☐ Insurance

☐ School Entry ☐ Other (please specify): _____

*I understand that if any of the information to be disclosed contains any of the types of records or information below, those specific records may have additional laws or protection related to disclosure and that I MUST INITIAL the specific types of information below before it can be disclosed:

☐ **Mental Health Information** (This may include records related to a medical diagnosis of Autism)

☐ **Genetics Testing Information** ☐ **HIV/AIDS Information** ☐ **Drug/Alcohol Treatment**

*PLEASE NOTE: You do not need to sign this authorization. Refusal to sign this authorization will not adversely affect your ability to receive health services or reimbursement for services. Your refusal to sign this authorization will not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is needed to help determine if you or the patient is eligible to enroll in the health plan.

*You may REVOKE this authorization at any time by sending a written statement to:
Speech & Play, LLC at 3869 SW Hall Blvd., Beaverton, OR 97005. If you revoke the authorization, the information described above may no longer be used or disclosed for the purpose identified above. Any use or disclosure made prior to written revocation cannot be undone.
*I understand that the information used or disclosed according to this authorization may be subject to RE-DISCLOSURE and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of records containing information regarding mental health, genetics, HIV/AIDS, and drug/alcohol treatment.

*I have read this authorization and I understand it. This authorization will EXPIRE ONE YEAR FROM THE DATE OF THE SIGNATURE unless revoked or otherwise specified: _____ (alternative expiration date)

SIGNATURE: _____ DATE: _____

*Relationship to the client (if signed by personal representative or legal authority): _____