speechcenter, inc.

Welcome to Speechcenter!

We would like to welcome you to our practice. Speechcenter, Inc. has been a leader in speech pathology services in North Carolina since 1982!

We hire only the best!!! Services will be provided by our renowned Speech-Language Pathologists. They are passionate and dedicated to the field of communication disorders. Each possesses a Master's Degree, a NCBOE SLP license, and are nationally certified in ASHA Clinical Competence or an ASHA Clinical Fellow.

Our clinic: Some insurers require services be provided in our office clinic. Other family members and younger children may stay in our child-friendly reception area during the visit.

How to contact your therapy provider: You will be given a phone number to contact your clinician. Please leave a message, as our staff is often serving patients. They check their messages frequently. If you have questions about therapy, notice changes or improvements, please communicate these in a timely manner with the clinician during the next visit or via phone. New goals can be developed to maximize therapy time, and we can celebrate progress together.

Visit Length: Visits last approximately 30 minutes. This time includes direct patient therapy and/or consultative time with the caregiver, since treatment plan success is a team effort.

Rescheduling or cancellations: It is important that we have as much advance notice as possible, at least 24 hours. However, if you do not show up or show up late it is time lost for you, the clinician and another patient who may have benefited from that time. Our staff are professionals and have many patients requiring our services. The time that we schedule for you is yours and we value that time.

Missed and late visits: If you schedule and do not show for 3 appointments, the patient may be discharged. If you arrive late for your appointment, your session will either be reduced by the number of minutes you are late or will be cancelled.

Billing & Payment: We are happy to bill your insurance after we have verified they will cover services. Any restrictions, limitations or out-of-pocket costs will be shared with you beforehand. Any charges not covered by your insurance, like copays or out-of-pocket expenses, will be your responsibility to pay. Please contact our administrative offices to settle your account. Any copay or out-of-pockets owed by you will be payable at each visit. We accept MasterCard, Visa and debit cards. A returned check fee of $25 may be charged for checks with non-sufficient funds.

Returning Forms or Consents: You have the option to fax, mail or email documents to us. Fax: 1-336-725-0454. Mail: 185 Charlois Blvd., Winston-Salem, NC 27103. You can also sign most documents electronically with your typed initials and email them back to medicalrecords@speechcenter.com

Should you have any questions, please communicate with your clinician. For other issues, please contact the following:

Toll-free and After-hours	Winston-Salem Area	Charlotte Area
Phone: 1-800-323-3123	Phone: 1-336-725-0222	Phone: 1-704-332-8033

New Patients:	Susan Kirkman or Rose Gonzalez
Administrative, Billing & Service Issues:	Pam Basch

Regional Clinical Supervisors, Clinical Questions and Concerns:

Charlotte Area:	Jeri Bates, VP, COO, CHC
Mountain Areas:	Jeri Bates, VP, COO, CHC
Winston-Salem Areas:	Caitlin Craven, MA, CCC-SLP

More information is available on our website: www.speechcenter.com

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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. It refers to practices followed by our medical and administrative staff. It refers to services provided at our office, the patient's home or other setting. If we have been contracted to provide services on behalf of another entity or in another facility not owned or operated by Speechcenter, other policies may apply. Notice effective date: 10/29/2015

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Our Uses and Disclosures

Treat you: We can use your health information and share it with other professionals who are involved in treating or coordinating treatment for you. For the purpose of continuing and coordinating a plan of treatment we may share your health information, or such portions relevant to speech language pathology, with facilities and appropriately-related professionals involved in your care. Example: We may discuss, disclose and/or coordinate provision of health care with a childcare provider, attendant family members, inclusive therapy setting, related school/daycare staff, the school system, a custodial foster family, CDSA case managers/staff, LEA representative and/or student SLP/SLPA, and others involved in your care to ensure we all have the necessary information to diagnose or follow a plan of treatment. We may share your health information with other individuals, which you have told us will be helping you with the therapy program.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance so it will pay for your services.

Run our organization: We can use and share your health information to run our practice and improve your care. We may contact you as necessary, at any of the phone numbers, addresses or email addresses you have provided or used to contact us. We may contact you via a phone call, voice message, email, text message and/or in writing, unless you request a more confidential communication method. We might also send you informative communications that do not include your health information but contain business updates, industry news or other health-related benefits that Speechcenter feels is necessary to share with its patients, unless you ask us not to.

Help with public health and safety issues: We can share health information about you for certain situations such as: reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety. We can share health information with a coroner/medical examiner when an individual dies.

Comply with the law and responding to legal actions: We will share information about you if state or federal laws require it, including with the Department of HHS if it wants to see that we are complying with federal privacy law. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Your Rights and Choices

Email or text messages: We may respond to you and/or contact you via email or cell phone text messages, unless you instruct us not to. If you communicate with us using email or text messages, we can assume that these types of electronic communications are acceptable to you and that you understand that electronic communications are not guaranteed as secure. You can ask us to stop emailing or text messaging you, at any time.

Receipt of Informative Communications: You can opt out of receiving informative business communications, such as business updates or industry news.

Request confidential communications: You can ask us to contact you in a specific way (for example, at your home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Sharing information: You can ask us to share information with your family, close friends, or others involved in your care.

Ask us to limit what we use or share: You can ask us in writing not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. Parents and guardians will generally have the right to control privacy of health information of minors unless the minors are permitted by law to act on their own behalf.

Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we will tell you why in writing within 60 days.

Get a list of those with whom we have shared information: You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Requests: All requests to exercise your rights or choices should be made in writing.

Get a copy of this notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Changes to the terms of this notice: We can change the terms of this notice at any time, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

File a complaint: You can complain if you feel we have violated your rights by contacting us the phone number below. You can file a complaint with the U.S. DHHS OCR by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

Questions, concerns or complaints?
Please contact:

Jeri Bates, Vice President, COO, CHC
Speechcenter, Inc.
185 Charlois Blvd.
Winston-Salem, NC 27103

www.speechcenter.com
Phone 1-800-323-3123

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General Patient Information

Patient Last Name	Patient First Name	Patient Middle Name	Patient DOB (*mm/dd/yyyy*) / /
Patient Street Address	City	State	Zip Code County
Patient Mailing Address (*if different from address above*)	City	State	Zip Code
Patient Home Phone Number	Patient Cell Phone Number	Patient Work Phone Number	
Patient Gender ☐ Male ☐ Female	Patient Marital Status ☐ Single ☐ Married ☐ Other	Patient Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student	
Patient School (*if school aged*)	Patient Email Address		

PARENT/Legal Guardian Information (*required only if patient is a minor*)

Legal Guardian Last Name	Legal Guardian First Name	Legal Guardian MI	Legal Guardian DOB (*mm/dd/yyyy*) / /
Legal Guardian Street Address	City	State	Zip Code
Legal Guardian Mailing Address (*if different from address above*)	City	State	Zip Code
Legal Guardian Home Phone Number	Legal Guardian Cell Phone Number	Legal Guardian Work Phone Number	
Legal Guardian Gender ☐ Male ☐ Female	Patient Relationship to Legal Guardian ☐ Child ☐ Other – Please Explain: _____		
Legal Guardian Email Address			

Patient Medical History

Name of Patient's Doctor:	Doctor's Phone Number
Doctor's Address City State Zip Code	
Please provide patient's brief medical history and any medical condition(s) contributing to speech, language or swallowing concerns: _____	
Is patient's condition related to: Employment? (*current or previous*) ☐ YES ☐ NO; An Automobile Accident ☐ YES – If Yes, what state? ___ ___ ☐ NO; Other Accident ☐ YES ☐ NO	
If Yes for any of the questions above, please provide date of occurrence (*mm/dd/yyyy*): / /	

Speech-Language Therapy Service Information

At what place of service or location will services be provided?	Place of Service Phone Number
Place of Service Address (*where therapy will occur*) City State Zip Code County	
Is the patient receiving additional speech-language therapy services in a school or with another provider? ☐ YES ☐ NO If Yes, please give provider name and contact phone number:	

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Patient Payment/Insurance Information

Patient Last Name	Patient First Name	Patient Middle Name	Patient DOB (*mm/dd/yyyy*) / /

☐ **Medicaid**	☐ **Health Choice**	☐ **Medicare**
Medicaid Recipient ID # _____	Health Choice Number # _____	Medicare Recipient ID # _____

Other Primary Health Insurance (This insurance must be billed BEFORE we can bill Medicaid)

Insurance Company Name			Policy/Group Number
Patient ID Number		Insurance Company Benefits & Eligibility Phone Number	
Policyholder's Last Name	Policyholder's First Name	Policyholder's MI	Policyholder's DOB (*mm/dd/yyyy*) / /
Policyholder's Street Address		City	State Zip Code
Policyholder's Home Phone Number	Policyholder's Cell Phone Number	Policyholder's Work Phone Number	
Policyholder's Gender ☐ Male ☐ Female	Patient's Relationship to Policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other _____		
Policyholder's Employer, School or University			

Other Secondary Health Insurance (This insurance must also be billed BEFORE we can bill Medicaid)

Insurance Company Name			Policy/Group Number
Patient ID Number		Insurance Company Benefits & Eligibility Phone Number	
Policyholder's Last Name	Policyholder's First Name	Policyholder's MI	Policyholder's DOB (*mm/dd/yyyy*) / /
Policyholder's Street Address		City	State Zip Code
Policyholder's Home Phone Number	Policyholder's Cell Phone Number	Policyholder's Work Phone Number	
Policyholder's Gender ☐ Male ☐ Female	Patient's Relationship to Policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other _____		
Policyholder's Employer, School or University			

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Patient Last Name	Patient First Name	Patient Middle Name	Patient DOB (*mm/dd/yyyy*)
			/ /

Consent for Services

I authorize Speechcenter, Inc. to render appropriate therapy services to the above named patient. I understand that care will be provided by an appropriately trained health care professional. I recognize and agree that I have the right to refuse treatment or terminate services at any time by notifying the Speechcenter, Inc. office in writing. In addition, Speechcenter, Inc. may terminate services by notifying me of termination. I hereby authorize Speechcenter, Inc. to bill any insurer identified as providing coverage for the insured and allow for the release of any information necessary to process claims for medical benefits.

Patient/Authorized Representative:

Printed Name: _____ Relationship to Patient: _____

Sign _____ Date Signed: _____

(Please type your initials if signing electronically.)

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Patient Last Name	Patient First Name	Patient Middle Name	Patient DOB (*mm/dd/yyyy*)
			/ /

Privacy Notice Acknowledgement

As a new patient, I hereby consent to and acknowledge receipt of Speechcenter's *Notice of Privacy Practices* or as a current patient, I consent to and acknowledge the availability of Speechcenter's *Notice of Privacy Practices.* I understand the notice explains my rights to privacy regarding my health information and provides information and a description of how my health information may be used and disclosed. My requests are recorded below.

I agree that Speechcenter, Inc. may communicate with me electronically at the phone numbers and/or email addresses I have provided or used to contact its staff, unless I have requested a more confidential means of communication in writing. By accepting electronic communications, I understand these cannot be guaranteed as secure forms of communication.

Additional persons AUTHORIZED to have access to my health record:

Parents/Legal Guardians:_____

Spouse/Partner:_____

Grandparent(s):_____

Other Family Member(s):_____

Other(s):_____

_____

Persons or entities <u>NOT</u> AUTHORIZED to have access to my health record:

_____

_____

Request for communication restrictions:

_____

_____

As used in this document, the terms "I", "me" and "my" refer to and include, in addition to the undersigned, the patient named above for whom the undersigned is responsible or for whom the undersigned has assumed responsibility engaging in Speechcenter, Inc. to provide services to the patient. This document supersedes and replaces any and all previous consents and authorizations. This consent and authorization is valid until revoked by me in writing.

Patient/Authorized Representative:

Printed Name: _____ Relationship to Patient: _____

Sign _____ Date Signed: _____

(Please type your initials if signing electronically.)