To All New Clients and Families:

We are happy to provide therapy services to your child and want to help them in every way we can. Our private practice has been in existence since 1981 and has a long history of providing high quality services and reliability to our clients.

We want you to know that we will make every effort to accommodate your scheduling requests into our therapists' schedules.

However, the days and times or therapist you have been assigned may not necessarily stay the same. Due to changing caseloads, your therapist's schedule may require altering your child's times slightly. Our scheduling team will communicate any changes to you as soon as possible.

Before we are able to treat your child, completion of the following paperwork is required. Please let us know if you need assistance or have any questions.

We're excited to be part of your child's team!

Thank you for choosing Speechcenter, a Sidekick company!

Speechcenter, a Sidekick company
www.speechcenter.com
185 Charlois Blvd, Winston Salem, NC 27103
(336) 725-0222

Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice explains how your medical information may be used and disclosed and how you can gain access to this information. **Please review it carefully.** We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. If you have any questions, you can call us at (336) 725-0222.

Your Rights
You have the right to:
- Obtain a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Obtain a copy of this notice
- Obtain a list of those with whom we have shared your information
- Choose someone to act for you or as your representative
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have a choice in the way we use & share information as we inform family, caregivers, & others interested in your care about your condition.

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Bill for your services
- Help with public health and safety issues
- Operate our healthcare organization. This includes (if applicable to you) obtaining permission from your child's insurance company to provide in-school IEP services and coordinating and managing those services with school system staff.
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions in compliance with the law

SMS & Texting
No Sharing of Mobile Information Clause.
No mobile information will be shared with third parties or affiliates for marketing or promotional purposes. All text messaging originator opt-in data and consent will not be shared with any third parties.
Online Contact Form Opt-In Clause.
By submitting your phone number, you authorize us to send you text messages regarding appointment reminders, scheduling, account updates, and any inquiries you may have. Message frequency varies. Data rates may apply. Text HELP for help, or for immediate help, you can call us at 336-725-0222. Reply STOP to unsubscribe from future messages.
Messaging Terms & Conditions.
When you opt-in to receive SMS/MMS communications from Speechcenter, you agree to receive appointment reminders, scheduling, account updates, and any inquiries you may have. Message frequency may vary. Message & Data rates may apply. You may opt-out at any time by texting STOP. For assistance you can text HELP or contact us at 336-725-0222.

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and our responsibilities to help you. **Inspect or obtain an electronic or paper copy of your medical record.**
- You can ask us to see or obtain an electronic or paper copy of your medical record & other health information we have about you.
- We will provide a copy or a summary of your health information, typically 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 explain why in writing within 60 days.

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

Ask us to limit what we use or share.
- You can ask us 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 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.

Obtain a list of those with whom we have shared information.
- You can ask for an 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. A request for such accounting will be responded to within 60 days, which may be a request on our part for an additional 30 days to respond and the reasons for such a delay.

• We will include all the disclosures except for those about treatment, payment, and health care operations, for such uses as separately and expressly authorized by you, and certain other disclosures, such as any you asked us to make. We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another within 12 months.

Obtain a copy of this privacy notice.

• You can request 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.

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.

File a complaint if you feel your rights are violated.

You can file a complaint if you feel we have violated your rights. Call us at 865-693-5622 and ask to speak to Krissie Self, email kself@mysidekicktherapy.com or write to us at the address listed at the bottom of page 2 of this notice.

You can file a complaint with the Secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html. We will not retaliate against you for filing a complaint with us or the Secretary of U.S. Department of Health and Human Services.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a preference for how we share your information in the situations described below, let us know. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us how to share information with those involved in your care.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

• **Treat you.** We can use your health information and share it with other professionals who are treating you or who have referred you to us for services. *Example: A doctor treating you for an injury asks another doctor about your overall health condition*.

• **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Comply with the law.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services to demonstrate compliance with federal privacy law.

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.

Respond to lawsuits and legal actions.

We can share health information about you in response to a legal order from a court or administrative order, or in response to a subpoena. Our Responsibilities:

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

• We must follow the duties and privacy practices described in this notice and give you a copy of it.

• 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.

For more information see: https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html**.**

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 website.

Other Instructions for Notice

• This notice is effective June 1, 2021. It replaces our earlier notice.

• Krissie Self is our company's privacy contact. You may contact her by phone at (865) 693-5622, email at kself@mysidekicktherapy.com, or write to the address at the bottom of the page.

Your child's public school system may have approved an Individualized Education Program (IEP) for your child that includes speech pathology services. If your child receives such IEP-related services, we will use or disclose your child's information and patient file to school system staff, including the school's Special Education Department. We provide this information to: (i) help the school system manage the services we provide to children with IEPs, and (ii) inform the school system and Special Education Department staff of your child's evaluation results, therapy, progress in therapy, and progress toward meeting your child's IEP goals.

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HIPAA Consent Form – Auth for Release of Health Info

Child's Name: _____ Child's date of birth: _____

I have received a copy of Speechcenter, a Sidekick company ("Speechcenter") Notice of Privacy Practices.

I authorize Speechcenter to use and disclose my child's complete patient file, including personal health information related to therapy and testing to: (i) my child's insurance company, (ii) my child's physician and other healthcare providers, and (iii) as provided in Speechcenter's Notice of Privacy Practices. This authorization is voluntary and once that information is disclosed, it may be re-disclosed and no longer be protected by federal privacy regulations if the recipient is not a healthcare provider. However, it is my understanding that Speechcenter does not disclose this information except to my health insurance company, other healthcare providers, or as provided in its Notice.

The purpose of Speechcenter's use and disclosure of this information is to facilitate Speechcenter providing therapy services to my child, obtain health insurance company authorization and payment for services, and coordinate or manage my child's care with other healthcare providers.

This authorization will be in force and effect for as long as my child is receiving services from Speechcenter and, after Speechcenter services end, for as long as the law or insurance company requires Speechcenter to preserve my child's records. I have the right to revoke this authorization at any time by writing to Speechcenter at the address listed below. Treatment, enrollment, eligibility, or benefits will not be conditioned on whether I sign this authorization.

I also consent to the use and disclosure of my child's complete patient file, including personal health information, for the purposes noted in Speechcenter's Notice of Privacy Practices or as otherwise authorized by law. I also consent to Speechcenter evaluating and providing therapy to my child and taking actions to establish and maintain my child's Medicaid or other eligibility for services, obtain payments from Medicaid or other insurance companies, and share the results of Speechcenter's testing and therapy with my child's insurance company and doctor.

I, _____ (PRINT CAREGIVER NAME), do hereby consent and acknowledge my agreement to the terms set forth in the Speechcenter NOTICE OF PRIVACY PRACTICES and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

Print Name: _____

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a sidekick company

Financial Agreement

Child's Name: _____ Child's date of birth: _____

Medicaid information (skip this section if not eligible for Medicaid coverage)

Medicaid program (will be billed after any primary commercial insurance on file):

- ☐ Direct
- ☐ WellCare
- ☐ UHC-Community Plan
- ☐ Healthy Blue
- ☐ Carolina Complete Health
- ☐ AmeriHealth Caritas of NC
- ☐ Partners
- ☐ Trillium
- ☐ Vaya
- ☐ Alliance (out of network)

Medicaid ID# (ex. 12345678L): _____

Primary insurance (*will be billed before Medicaid if eligible*): _____

ID#: _____ **required*

Group#: _____

Primary policy holder's full name: _____

Primary policy holder's date of birth: _____ **required*

Primary policy holder's phone #: _____

Primary policy holder's relationship to patient: ☐ mother ☐ father ☐ other: _____

Secondary insurance (*if applicable*): _____

ID#: _____ **required*

Group#: _____

Primary policy holder's full name: _____

Primary policy holder's date of birth: _____ **required*

Primary policy holder's phone #: _____

Primary policy holder's relationship to patient: ☐ mother ☐ father ☐ other: _____

All therapy fees including co-pays, co-insurance & *Private Pay payments are due at time of service.
***Private Pay**: Patients without insurance coverage or are covered by an insurance plan our office does not participate in.*

Forms of Payment: We accept American Express, Discover, Mastercard Visa and personal checks. We DO NOT accept cash payments.

Verification of Benefits: As a courtesy, Speechcenter will contact your insurance provider to obtain benefit information including deductible, copay, co-insurance amounts, visit limits and prior authorization requirements. (Prior Authorization may be required by your carrier after an evaluation has been completed.)

This information is obtained as a good-faith effort and is never a guarantee for payment. The insurance company makes the final decision regarding your eligibility and benefits. If your provider determines any services are "not covered" or are denied, you will be responsible for any and all outstanding charges. **It is the patient's responsibility to know the terms of their insurance plan.**

Change in Carrier or Benefits: If you have a change of insurance provider, or a change of health benefits please notify our office immediately. Your account and billing information will be updated, and a new verification of benefits will be completed.

By signing below, I / We agree to pay for all services rendered. Speechcenter may bill the insurance carrier for services provided and may extend payment for ninety (90) days to allow sufficient time for the insurance company to pay. However, if payment is not received within 90 days of services being rendered, we agree to pay Speechcenter immediately.

Automatic Payment Consent

I authorize Speechcenter to securely store my credit card information and charge my card on file for insurance copays and coinsurance related to therapy services rendered. I understand that copays will be charged weekly for provided services.

I understand that if I have a balance with Speechcenter after my insurance company processes my claim - including deductible, coinsurance, and copays - I will be responsible for paying the balance due monthly.

I agree to update my payment information promptly if my card expires, is lost, or if my billing information changes.

I have read the above policies, understand them, and agree with them.

Signature: _____ Date: _____

Print Name: _____

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a sidekick company

Attendance Policy

Child's Name: _____ Child's date of birth: _____

A healthcare relationship is built on mutual trust and respect. To meet the needs of our clients and provide effective treatment, regular attendance is necessary. We strive to be on time for scheduled appointments, and we appreciate you being respectful of the needs of other clients and your child's therapist.

Teletherapy appointments are also available to help meet attendance requirements. If you are unable to regularly attend in person, please let the clinic know and we can discuss options.

Emergency Cancellation: We understand emergencies arise due to illness, illness of family member, death in the family, etc. We ask that you contact our office as soon as possible to report an emergency.

Non-Emergency Cancellation: ALL non-emergency cancellations must be within 24 hours prior to your scheduled appointment. Appointments are in demand; your early cancellation allows us time to reschedule with another family in need of an appointment.

How to cancel an appointment: Call or text the clinic at (336) 725-0222 and speak to the administrator or you may leave a detailed message on our voicemail which is available 24 hours a day.

No-show: A "no-show" is a missed scheduled appointment without notification of cancellation. It also includes being more than 15 minutes late for an appointment.

Make Up Sessions: Contact the clinic to discuss availability for a make-up session with your therapist or another therapist who is available.

Frequent Cancellations or No-Shows: If the attendance rate falls below 75% or a client with late cancellations more than 25% of the time during any month will have the number of weekly appointments reduced (usually from 2 appointments to 1). If they are able to make these appointments, we may resume more frequent therapy sessions. However, if the client continues to miss these reduced appointments, they may be discharged.

Speechcenter reserves the right to suspend services at their discretion.

I agree to all the terms of this policy and understand that frequent cancellations and no shows may result in reduced therapy sessions or discharge from this practice.

Signature: _____ Date: _____

Print Name: _____

Consent Forms

Child's Name: _____ Child's date of birth: _____

Photograph/Video for Social Media & Marketing

I consent and authorize Speechcenter, a Sidekick company ("Speechcenter") to use my likeness in any photograph, video, or other digital media in any and all of its publications, including print or web-based publications and social media.

I hereby grant permission to Speechcenter and its employees the irrevocable and unrestricted right to reproduce the photographs and/or video images taken of me, or members of my family, for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium, including print, web-based publications, and social media. I irrevocably authorize Speechcenter to copy, edit, enhance, crop, or otherwise alter any photo for use in their publications. I also waive any rights for approval or inspection of any photos. I understand that I am under no obligation to consent.

I understand that all photos and video are property of Speechcenter. I hereby release Speechcenter and its legal representatives for all claims and liability relating to said images or video. I waive my right to any compensation.

Note: Last names or addresses will never be included in print, web, or on social media.

Signature: _____ Date: _____

Print Name: _____

Audio/Video for Treatment Planning Only

I hereby grant permission to Speechcenter, the rights to record my child's therapy session (in person or via teletherapy) and of the likeness and sound of my/my child's voice as recorded on audio or video tape. **I understand that this audio and/or video is to be used for the purposes of evaluating and treating the client and the accompanying impairment and is used to assist Speechcenter's Therapists in determining a diagnosis and treatment plan. I understand that this material may also be used to train other Speechcenter therapists within the organization but will not be distributed.** The audio/video for the client will be stored securely in the client's file within our organization. I waive any right to royalties or other compensation arising or related to the use of the recording. There is no time limit on the validity of this release. This release applies only to audio or video recordings collected as part of the evaluation and treatment sessions performed for the client.

Signature: _____ Date: _____

Print Name: _____

Consent Forms (cont.)

Child's Name: _____ Child's date of birth: _____

College and University Partnerships

Speechcenter appreciates the need to train professionals in speech therapy. We occasionally partner with local colleges and universities whose students observe and take part in our therapy sessions under 100% supervision of our certified therapists. We will inform you if there will be a college or university student involved in your child's therapy session and you always have the option to switch to another therapist if you would like. If you have any concerns about this, please talk to your child's therapist.

My signature below verifies I have read this statement.

Signature: _____ Date: _____

Print Name: _____

speech center
a sidekick company

Patient Information

Patient's Full Name: _____
(FIRST) (MIDDLE) (LAST)

Patient's Date of Birth: _____
(MM/DD/YYYY)

Patient's Sex: ☐ Male ☐ Female

Caregiver's Email (clearly PRINT): _____@_____.com

Caregiver's Phone #: (_____)_____

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 BY RESPONDING WITH THE OPT-OUT MESSAGE "STOP".

Patients' Street Address: _____
(STREET) (CITY) (STATE) (ZIP)

Patients' Mailing Address: _____
(STREET) (CITY) (STATE) (ZIP)

Legal Guardian's Full Name: _____
(FIRST) (LAST)

Relationship to the patient: ☐ mother ☐ father ☐ other: _____

Additional Legal Guardian's Full Name: _____
(FIRST) (LAST)

Relationship to the patient: ☐ mother ☐ father ☐ other: _____

Legal Guardian's Mailing Address *(if different than patient's)*: _____
(STREET) (CITY) (STATE) (ZIP)

Name of Patient's Primary Care Physician: _____
(REQUIRED FOR MEDICAID)

Primary Care Physician's OFFICE NAME & LOCATION: _____
(OFFICE NAME)

_____
(STREET) (CITY) (STATE) (ZIP)

(_____) _____
(OFFICE PHONE#)

Patient's Medical History (please provide patient's brief medical history & any medical condition(s) contributing to speech, language, or swallowing concerns): _____

_____

_____

_____

_____

_____

Location services will be provided: ☐ Clinic ☐ Virtual ☐ School: _____ ☐ Daycare: _____

Is the patient receiving additional speech-language therapy services in a school or with another provider?
☐ No
☐ Yes - Please give provider name & contact info: _____
(provider's name)

(_____) _____
(provider's phone#)

_____ _____
Guardian Signature Date signed

Teletherapy Consent Form

I, _____ (PRINT GUARDIAN NAME), do hereby consent to participate in teleservices with **Speechcenter, a Sidekick company** during the period of an office closure or periods when in-person services are unavailable. I understand that this consent shall remain in effect from this time forward until I elect to discontinue these teleservices in writing.

I understand that teleservice will be used to deliver therapy services via technology assisted media or other electronic means between a Speech Language Pathologist or other professional practitioner, as agreed, and a client who are in two different locations. I understand the following with respect to teleservices:

1) I understand that I have the right to withdraw consent at any time without affecting my child's right to future services, or program benefits to which my child would otherwise be entitled.
2) I understand that there are risks and consequences associated with teleservices, including but not limited to, disruption of transmission by technology failures, interruption and/or unintended breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my child's protected health information (PHI) also apply to teleservices unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others).
5) I understand that if my child is experiencing a mental health crisis that cannot be resolved remotely, it may be determined that teleservices are not appropriate, and a higher level of care is required.
6) I understand that the Health Insurance Portability and Accountability Act of 1996 prohibits any further disclosure of this information without my specific written consent, or as otherwise permitted by such regulations. I understand that I have the right not to consent to disclosure of this information. I understand I have the right to revoke this authorization at any time. I understand that this consent shall remain in effect until revoked by me, in writing, and delivered to Speechcenter, but that any such revocation shall not affect disclosures previously made by Speechcenter prior to the receipt of any such written revocation.

Recommendations for a successful teleservices session:

- ✓ A laptop or personal computer with a camera and microphone and internet access is ideal; however, a smart phone with a camera may also work.
- ✓ A "quiet area" that is not accessible by other children or pets during the session.
- ✓ An adult who can assist your child with connecting, troubleshooting any connection issues, remaining online during the session, and navigating the session activities.

I understand that during a teleservice session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please contact our office at 865-693-5622 to discuss as we may have to reschedule.

_____ _____

Child's Name [print] Date of birth

_____ _____

Guardian Signature Date signed