HIPAA Notice of Privacy Practices
High Desert Speech and Language Center, Inc

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.

Understanding your health information

High Desert Speech and Language Center, Inc offers numerous types of clinical services in the areas of speech, language, and hearing You may visit a clinic for the purpose of an assessment or for on-going treatment. When you visit a clinic, a record of your visit is made and this record of your communication skills is considered part of your health information. This record includes subjective and objective information about your communication skills as documented by diagnostic reports including test results and referral information, a plan of treatment, daily progress notes (S.O.A.P.) and progress reports. This information is maintained in a chart and is an essential part of the services we provide for you. Your chart contains personal information and there are state and federal laws to protect the privacy of this information.

Uses and Disclosures of Health Information

· ***We will use your information for treatment***

The clinical staff involved in your care will document in your record results of your assessment or the plan of treatment established for you. If you were referred to us from another provider, the clinicians may send copies of your record to the doctor who referred you to us so your doctor will have updated treatment information about your care.

We will provide your future physicians or subsequent healthcare providers with copies of various reports that should assist him or her in treating you.

We may also use health information aoout you to call you or send you a letter to remind you about an appointment, to follow up with tests results, orto provide you with information about other treatment and care that could benefit you.

· ***We will use your health information for payment***

A bill will be sent or given to you or your third party payor (insurance). The information on or accompanying the bill may include information that identifies you, as well as your diagnoses, procedures, healthcare providers and supplies used. We also may contact your insurance company to determine rf they will pay for your diagnostic or treatment as part of their certification process.

Communication with others involved with your care

We may disclose to a family member, or other relative, close personal friend or any other person you identity, health information directly relevant to that person's involvement in your care or payment related to your care.

The disclosure will only be done if you agree, do not express an objection when given the opportunity, or we believe, based on the circumstances and our professional judgment that you do not object.

Required by Law

We may also disclose health Information without your consent or authorizaton required by law to the Governmental agencies.

Other uses and disclosures from your medical record will be made only with your written authorization or approval.

Patient Rights

You have the right to:

- Inspect and obtain a copy of your health record. There may be a charge to cover the cost of copying your record.
- Request an amendment of your health records.
- Obtain an accounting of nonauthorized disclosures of your protected health information (these are mandated reporting laws such as child abuse), including research projects approved by the IRB.
- Request communication of your health information in a certain way or at a certain location. For example, you can ask that we contact you by mail and not by telephone, or that we contact you at a specific telephone number, or that we use an alternative address for billing purposes, or that we not leave messages on certain answering machines.
- Revoke your authorization to use or disclosure health information except to the extent that action has already been taken.
- The right to request restrictions on certain uses and disclosures of your protected health information which we may or may not agree to but if we do, such restrictions shall not apply unless our agreement is changed in writing.

  To exercise any of these rights, your request must be in writing.

Our duties

We are required by law to maintain the privacy of your protected health information;

- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect about you through this notice;
- Abide by the terms of the notice currently in effect;
- Notify you if we are unable to agree to a requested restriction;
- Follow reasonable requests you make to communicate with you as you instruct- for example, contact you at a certain telephone number or address.

Provide you a paper copy of this notice of privacy practices upon request.

I understand and agree to my privacy rights as expressed above

_____ _____

Patient Signature/Parent **Date**

HIGH DESERT
SPEECH AND LANGUAGE CENTER, INC.

CASE HISTORY FORM-Child

Please fill out this form as completely as possible, especially the questions marked with an asterisk If you need more space, write on the last page, or add a sheet.* Date:_____

Person filling out this form:_____ Relationship to child:_____

Identifying Information

*Child's name:_____ *Birth date:_____ Age:_____ Gender: F M

*Parents or Guardians:_____

Phone: (home)_____(cell)_____ _____(work)_____

Responsible Party Social Security Number:_____

Email:_____

Address:_____

City:_____ State:_____ ZIP:_____

^Reason for referral:_____ Referring person:_____

History of Problem

^Describe present problem:_____ _____ _____

_____

_____

Who noted present problem?_____ When?_____

*What is your child's reaction to the problem?_____

_____

*How does the family react to the problem?_____

_____

Has there been any significant change in last six months?_____If so, what?._____

_____

*How well is your child understood by: (i.e., what percentage of the time)

Mom:_____ Dad:_____ Younger siblings:_____ Older siblings:_____

Other children:_____ Extended family:_____Unfamiliar adults:_____

*Describe what it is like to have a conversation with your child:_____

_____

_____

*Any previous assessments? Y N Where?_____ By whom?_____

*What kind?_____ _____

*What were the results?_____

*Which tests were given?_____

*Any previous therapy? Y N Where?_____ _ With whom?_____

Health History

Birth History

What was the length of the pregnancy?_____

*Were there any illness or accidents during pregnancy? (explain)_____

*Were drugs or alcohol used during pregnancy? (aspirin and/or other medication) Y N If so, what?

What was the length of labor?_ *Any difficulties at birth, including Caesarian?(describe):

Were drugs used?____ Instruments?_____ Bruises to head?_____

What was the mother's age:_____ Mother's health at time of pregnancy and birth was:

What was the final Apgar score? _____ Any jaundice? Y N cyanosis? Y N Rh incompatibility factors? Y N

Medical History

* Please check if your child has had any of the following (and if so, at what age):

____ Seizures	____ High fevers	____ Measles	____ Mumps
____ Chicken pox	____ Whooping cough	____ Diphtheria	____ Croup
____ Pneumonia	____ Tonsillitis	____ Meningitis	____ Encephalitis
____ Rheumatic fever	____ Tuberculosis	____ Sinusitis	____ Chronic colds
Enlarged glands	Thyroid	Asthma	Heart trouble

Please explain any checked items here:

Are immunizations current?_____Current general health:_____

**Has your child had any earaches/ear infections? Y N Please explain here:

Allergies? (Describe)_____

Any other serious or recurrent illnesses?_____

Any operations?_____

Any accidents? _____.

Any medications? (Past) *Hearing difficulties:___

Vision problems?_____

(Current)
Treatment:
Treatment:

Dental problems?_____ Treatment: _____

Other Medical History:_____

****If your child has had chronic ear infections and/or had tubes placed in his or her ears, please attach or have a statement sent from your doctor regarding dates and results of treatment.**

Personal Medical Information

Personal Primary Physician: Date of last visit:

Address or Location:

Ongoing Medical Care (Describe):

Physician's Name: City:

Current Medications: Dosage: Physician: Location:

Chronic Health Problems (Asthma, Congenital Defects, etc.):

Handicaps (Describe, if any):

Developmental History

Age when child: (If you can't remember specific time, please indicate if it occurred at the expected time or was delayed)

sat up alone_____ crawled_____ walked_____ toilet trained_____ dressed self

tied shoes_____ fed self independently_____ Is the child left or right handed?_____

Attention span-for self-directed activities:_____

* Attention span for adult-directed activities:_____

Eating and sleeping patterns:_____

Does your child respond to: Light?_____ Sound?_____ People?_____

Does your child: Play with others?_____ Who?_____

Eat and sleep well?_____ Cry appropriately ?_____ Laugh?_____ Smile?_____

Make wants known?_____ How?_____

Does your child show unusual behavior (explain)?_____

Language Development

Language(s) spoken in home:_____

*Age when your child spoke first word:_____ *combined words:_____*spoke in sentences:_____

*What was your child's first word(s)?_____ *first sentence?_____

*Which sounds (if any) are incorrect?_____

*How many words can your child say? (list if fewer than fifteen)

*How long are your child's sentences?_____

*Does your child have any difficulty understanding you? (describe) _____

*Does your child have difficulty following directions? (describe)_____

*Any speech or hearing problems in the immediate or extended family (explain)?

Social Development

Names and ages of siblings:

Other adults living in the home:_____

Moves prior to age 10:_____

Has your child attended day care?_____ Nursery School?

Number of regular playmates: Ages:_____ Genders:

Activities shared with parents and siblings:_____

*How does your child handle frustration:_____

conflict: _____ ■_____ separation:____

Regular responsibilities:_____

Favorite places:_____ people:_____ toys:_____

snacks:_____ _____ activities:_____ _TV programs:

What motivates your child most?_____

What discipline methods work best?_____

School History

School experience:_____

How does your child's teacher describe his/her performance?_____

Has the teacher expressed any concern? If so, what?

Other

*What do you hope to have happen as a result of this evaluation?,

*Does the report need to be sent to specific agencies?____ Where?

*Anything else you would like us to know?

HIGH DESERT
SPEECHAND LANGUAGE CENTER, INC.

UPDATED MISSED APPOINTMENT/ CANCELLATION POLICY

Effective November 1st 2013

Due to the availability of appointment times and our growing waiting list, we have made an addendum to our missed appointment /cancellation policy:

Missed Appointment Type	Penalty
No Call / No Show to appointment	**1st time:** $20 fee MUST be paid before the next appointment. No Exceptions. **2nd time:** You will be permanently taken off of the clinic schedule.
Missed appointment with less than 24 hour notice	**1st time:** $20 fee MUST be paid before the next appointment. No Exceptions. **2nd time:** You will be placed on our wait list until a more suitable time becomes available.

**A *courtesy* call is scheduled to go out the day before your appointment. If for any reason you do not receive a call, you are still responsible to attend scheduled appointments. **

This policy will be strictly enforced. It is our goal to provide the best service to all of our customers. We thank you in advance for your understanding.

We ask that you sign and return the bottom this form. If you would like copy of this signed form, we will be happy to provide one for you.

I have read, understand, and agree to the updated Missed Appointment Policy. After second missed appointment, when at least twenty-four hours notice is not given, I will give up my time slot.

_____ _____

Client or responsible Party Date

HIGH DESERT
SPEECH AND LANGUAGE CENTER, INC

OUR FINANCIAL POLICY

Thank you for choosing our clinic! We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign, prior to any of our services.

1) **FULL PAYMENT & COPAYMENTS ARE DUE at time of service.**

2) **We accept cash, checks, and all Major Credit Cards.**
REQUIREMENT: AH clients must provide a credit card number to be kept on file. ***This card will be charged for outstanding balances older than 30 days vast due.***

REGARDING INSURANCE
Payment for services is due at the time services are rendered unless you are referred by one of HDSLC, Inc. contracting insurance providers. If you are not a member of an authorized insurance plan, you are responsible for payment immediately following therapy/assessment. You can use your receipt to submit a claim to your insurance company for any amount your coverage allows (if any). Regardless of your assigned benefits, you are responsible for the total charges for services rendered. By signing this form, you are accepting all responsibility for full payments of services, if your insurance company denies your claim.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. If you would like a copy of this signed form, we will be happy to provide one for you.

I have read, understand, and agree to the above Financial Policy.

_____ _____
Client or Responsible Party Date

Allergy Information Form

Name:_____DOB: _____ _____
Date:_____
Person filling out form:_____ Relationship: _____

The above patient experiences allergic reactions to the following list of foods and/or other allergens or items.

Foods Not To Be Served:_____
_____
_____
_____

Other Allergens or Items:_____
_____
_____
_____

Cautionary Procedures : _____
_____
_____
_____

Signature of Client or Caregiver_____
Date: _____

HIGH DESERT
SPEECH AND LANGUAGE CENTER, INC.

Permission to Use Photography/ Video

Location: High Desert Speech and Language Center, Inc.

I grant to HIGH DESERT SPEECH AND LANGUAGE CENTER, INC. its representatives and employees the right to take photographs or video of my child or myself during speech therapy activities or workshops and be used for education purposes. I authorize High Desert Speech, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that High Desert Speech may use such photographs of my child or myself with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature_____ (parent or guardian, if under age 18)
Printed name_____ Relationship_____
Patient name_____

Date_____

Lakieta Emanuel (High Desert Speech Director)

Alyssa Arispe (Customer Care Representative)

Health Insurance Portability and Accountability Act

Health Insurance Portability and Accountability *Act: a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers*

Please print the telephone numbers and address where you would want to receive calls and information about your appointments or other issues that would come directly from our office staff members.

Home Phone f_____1_____ - _____
Cell Phone f_____1_____ - _____
Work Phone (_____] _____ - _____

Address: _____
_____
_____

Please list the family member or other persons, whom we may share information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This information is good for 5 years from the signed and agreed date, unless a written notice is received from the responsible party with any changes.

Patient Name: _____

Parent Name: _____

Parent Sign: _____

Date: _____