

PATIENT HEALTH HISTORY

Last Name _____ First Name _____ Today's Date _____

Nickname _____ Age _____ DOB _____ Male ___ Female ___

Address _____ City _____ State ___ Zip Code _____

Phone (H) _____ (C) _____

Email Address _____

School _____ Activities _____

Who referred you to our office? _____

Please give a brief description of the reason for your visit _____

Responsible Party

Last Name _____ First Name _____ Home Phone _____

Address (if different from above) _____

Occupation _____ Employer _____ Work Phone _____

___ Single ___ Married ___ Divorced ___ Separated O.k. to contact you at work? Y ___ N ___

Spouse _____ Home Phone _____

Address (if different from above) _____

Address (if different from above) _____

Occupation _____ Employer _____ Work Phone _____

Did the mother have any illnesses or complications during pregnancy and birth? ___ Yes ___ No

If yes, explain: _____

Did the mother take any prescription or non-prescription drugs (including alcohol) during pregnancy?

___ Yes ___ No If yes, what kind, how often, and how much? _____

Was the pregnancy full term? ___ Yes ___ No

If premature, how long was the pregnancy? _____

How much did the baby weigh at birth? _____

Did your newborn have any of the following difficulties? Fever Allergies Convulsions
 Excessive vomiting Bleeding Brain injury Feeding problems Breathing problems

Explain any medical difficulties of your newborn _____

Please give approximate ages at which the following occurred:

Motor Development

Sat alone _____ Crawled _____
 Stood alone _____ Walked alone _____
 Fed self _____ Dressed self _____
 Toilet trained _____

Speech/Language Development

Babbled _____ Spoke first words _____
 Put words together _____

Has the child's development appeared to be normal? ___ Yes ___ No If no, explain _____

III. MEDICAL INFORMATION

Health Care Providers

<p>Dentist: Name: _____ Address: _____ City, State, Zip: _____ Phone : _____</p>	<p>Ortho: Name: _____ Address: _____ City, State, Zip: _____ Phone : _____</p>
<p>MD: Name: _____ Address: _____ City, State, Zip: _____ Phone : _____</p>	<p>Other: Name: _____ Address: _____ City, State, Zip: _____ Phone : _____</p>

Has the student ever had high fever, serious illnesses, accidents or head injuries? ___ Yes ___ No
 If yes, describe and tell at what age it occurred _____

Did the condition described above require treatment in hospital? ___ Yes ___ No
 If yes, which hospital and for how long? _____

Does the student have frequent illnesses or health problems? ___ Yes ___ No
 If yes, explain _____

Does the student take a prescription medication? ___ Yes ___ No
 If yes, list medication(s), dosage, and purpose _____

Does the student have vision or hearing problems? ___ Yes ___ No

If yes, explain _____

Has the student experienced any events that could affect school performance (death in the family, divorce)?

Does the student have a tendency towards:	Colds	Sore Throats	Ear Infections	Headaches
--	--------------	---------------------	-----------------------	------------------

How Often? _____

	Yes	No
Have the Tonsils and/or Adenoids been removed? If so, at what age? _____		
Does the client have jaw popping and/or pain?		
Does the client have frequent headaches?		
Has there ever been an injury to the face or mouth?		
As the client ever sucked his/her thumb or fingers? If so, until what age? _____		
Does the client have any speech problems?		
Does the client breathe through his/her mouth while awake?		
Does the client breathe through his/her mouth while asleep?		
Does the client clench or grind his/her teeth at night?		

Please list any drugs or medications currently being taken: _____

Other pertinent Health information? _____

V. EDUCATIONAL BACKGROUND

Has this student been evaluated for special education previously? ___ If so, explain outcome:

Did this student attend kindergarten? _____ Full Day _____ Half Day _____ Didn't attend

How would you describe the student's ability to learn? ___ Average ___ Above average ___ Below Average

How would you describe the student's effort to learn? ___ Average ___ Great deal of effort ___ Little effort

Has the student ever missed over 10 days of school during the same year? ___ Yes ___ No If yes, explain

Has the student repeated a grade? ___ Yes ___ No If yes, which? _____

READING (decoding)

___ Above average ___ Average ___ Below Average

READING (Comprehension)

___ Above average ___ Average ___ Below Average

WRITTEN LANGUAGE

___ Above average ___ Average ___ Below Average

Describe any concerns the parent has about the student's learning or school performance. _____

Strengths/Interests/learning preferences (Please write at least one for each of these areas)

Motor Skills: Gross Motor (i.e. P.E. skills, running, jumping etc.)

___ Above average ___ Average ___ Below Average

Fine Motor (i.e. writing, cutting, manipulating small objects)

___ Above average ___ Average ___ Below Average

Comments:

Social/Emotional Development

- Gets along well with others
- Adequate social skills
- Good peer relations
- Adequate peer relations
- Social skills need improvement
- Difficulty maintaining friendships

DIET JOURNAL

Introduction to 5-7 Day Diet :: It is important to know what foods your child is choosing or not choosing to eat and where they are chewing the food once it is in their mouth. To pinpoint the answers, it is important that you, the food provider, tabulate a 5-7 day diet of what your child is or is not consuming.

- 1) Please tabulate your child's food choices / preferences: _____

- 2) What tastes, textures, temperature and shape do they prefer? _____

- 3) Is your child biting off food to take in their mouth:
 Between front teeth _____
 Between middle teeth _____
 Between back molars _____
- 4) Where are they chewing food once it is in their mouth?
 Front _____
 Middle _____
 Back _____
- 5) Their mouth is opened _____ / closed _____ as they chew.
- 6) How much jaw movement is accompanying the chewing?
 Very little _____
 Moderate amount _____
 A whole lot _____
- 7) Is the lower jaw jutting out? Yes _____ No _____
- 8) Is the lower jaw sliding from side to side? Yes _____ No _____
- 9) I your child stuffing their mouth regularly? Yes _____ No _____
- 10) Is your child taking tiny mouse-size bites? Yes _____ No _____
- 11) Are liquids used to wash down food? Yes _____ No _____
- 12) Does your child tip their head forward to swallow? Yes _____ No _____
- 13) Does your child tip their head backward to swallow? Yes _____ No _____
- 14) Does your child tip their head sideways to swallow? Yes _____ No _____

Observe and record your findings here and on the "7-Day Diet" Log sheet attached. Please return this form and the completed log during your child's evaluation or within 7 days.

We can then discuss increasing / decreasing textural demands and proper chewing habits the child can develop while acknowledging their taste preferences.

Thank you for your help and cooperation in this task.

7-DAY DIET LOG

Parents :: Please keep a 7-day diet log on this page. Write down everything your child will and will not eat for each meal and snack for 7 days. Answer the yes / no questions on the first page. Please return this finished log and the completed introduction page at their initial evaluation or within 7 days. Thank you for your help!

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
BREAKFAST							
LUNCH							
SNACK							
DINNER							
SNACK							

HOME OBSERVATION CHECKLIST

Name: _____

Date: _____

Please check all that apply within the next 48 hours ☺

<p>1) Usual position of the lips and teeth during daytime.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Open wide <input type="checkbox"/> Open slightly <input type="checkbox"/> Closed <input type="checkbox"/> Lips closed, but jaw position is low <input type="checkbox"/> Lips closed, but strong contraction of the chin and lip muscle <input type="checkbox"/> Teeth positioned over the lower lip 	<p>4) Usual position of the tongue during daytime</p> <ul style="list-style-type: none"> <input type="checkbox"/> Protruding between both teeth and lips <input type="checkbox"/> Protruding slightly between teeth <input type="checkbox"/> Low positioned, pressing against lower teeth <input type="checkbox"/> Unobservable, lips closed
<p>2) Usual position of the tongue, lips and teeth during sleep</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lips slightly parted <input type="checkbox"/> Lips apart, tongue showing <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Lips Closed 	<p>5) Sleeping posture</p> <ul style="list-style-type: none"> <input type="checkbox"/> Back <input type="checkbox"/> Left Side <input type="checkbox"/> Right Side <input type="checkbox"/> Stomach (face left/right side)
<p>3) Chewing patterns</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chews with lips open <input type="checkbox"/> Chews with excessive lip and chin movement <input type="checkbox"/> Chews with lips closed <input type="checkbox"/> Noisy chewing, smacking <input type="checkbox"/> Forward thrusting of tongue during chewing <input type="checkbox"/> Reaching out with tongue to meet food or liquid <input type="checkbox"/> Touching of teeth to utensil, cup or glass <input type="checkbox"/> Excessive crumbs around mouth and frequent lip licking <input type="checkbox"/> Mustache after drinking <input type="checkbox"/> Large bites <input type="checkbox"/> Fast chewing <input type="checkbox"/> Slow Chewing 	<p>6) Oral habits</p> <ul style="list-style-type: none"> <input type="checkbox"/> Thumb or finger sucking <input type="checkbox"/> Tongue sucking <input type="checkbox"/> Lip Biting <input type="checkbox"/> Lip licking (chapped lips) <input type="checkbox"/> Pencil biting <input type="checkbox"/> Finger nail biting <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Tooth grinding (bruxing) <input type="checkbox"/> Drooling <input type="checkbox"/> Facial, tooth, head or neck pain <p>7) Day time body posture</p> <ul style="list-style-type: none"> <input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good <input type="checkbox"/> Face Leaning <input type="checkbox"/> Chin Leaning <input type="checkbox"/> Phone resting on shoulder



Additional comments?

MYOFUNCTIONAL THERAPY APPROACH

We prefer to use a positive approach to eliminate such oral dysfunctions as mouth breathing, open mouth posture with lowered tongue position, and tongue thrust by strengthening the muscles of the facial network. This is a psychophysiologic approach which is aimed at coordination of muscle groups as routine for normal deglutition and articulation from a positive reinforcement exercise regimen.

Therapy is an eight-step program (not necessarily an eight-week program):

- 1) Directed at the tip of the tongue, establishing the placement of the tongue to achieve a labioglossal seal.
- 2) Aimed at strengthening the musculature that elevates and supports anterior tongue segments
- 3) Repositioning posterior tongue for resting and for speech.
- 4) Integration of new swallow with correct resting posture of the anterior segment of the tongue.
- 5) Establishing new patterns of deglutition on a conscious level.
- 6) Establishing new patterns for subconscious control of chewing, swallowing and tongue resting position.
- 7) Determination of the correct subconscious tongue position for resting posture.
- 8) Final concerns and evaluation of total pattern of facial musculature.

Recheck at any change in oral environment: Bands off, retainer, extractions, etc., or if the referral source desires. Patient is dismissed from therapy when at least one recheck, after a three month lapse, demonstrates correction and proper use of muscles to the complete satisfaction of clinician and patient.

NOTICE OF THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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. We are required by federal law to maintain the privacy of your Protected Health Information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. “Protected Health Information” is information that we keep in electronic, paper or other form, including demographic information collected from you and is created or receive by us relates to your past, present, or future physical or mental health condition, the provision of health care services to you or the past, present, or future payment for the health care services we deliver to you, and that identifies you or which we reasonably believe can be used to identify you. We are required by federal law to comply with the terms of this notice. We reserve the right to make changes in our privacy practices regarding your protected health information. If we change our privacy practices, which change will apply to all protect health information that we maintain about you. However, before we change our privacy practices, we will provide you with written notice of any changes. We may use and disclose your Protected Health Information for a variety of purposes. For example:

- 1) Treatment: We may disclose you protected health information to another physician, such as a specialist, to whom we refer you for medical treatment. THE FOLLOWING AUTHORIZES Speech Solutions TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATION:
 - a. I give permission to Speech Solutions to use my name, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email messages, text messages, and information about treatment alternatives or other health related information.
 - b. I give permission to Speech Solutions to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY. By signing the following, you are giving Speech Solutions permission to use and disclose your protected health information in accordance with the directives listed above.
- 2) Health Care Operations: We may disclose your protected health information to a health plan, managed care plan, individual practice association or to a management services organization that analyzes our delivery of medical services to evaluate our health care quality management, case management or professional competence. We may also provide your protected health information to other health care providers, such as laboratories or ambulance companies, for purposes of their health care operations.
- 3) Payment: We may disclose your protected health Information to obtain payments. Disclosures for “payment” include: a) disclosure to a health plan to determine your eligibility or coverage under the plan; b) billing services or collection agencies, c) disclosures to billing services or collection agencies, d) disclosures for utilization management and determinations of whether the medical service we deliver to you are necessary or appropriate, or e) disclosures to determine whether the amount we charge you for medical services are justifiable.

- 4) Reminders and Treatment Alternatives : We may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in connection with treatment, payment, or health care operations we deliver health care products or services to you based on the orders of another health care provider, and we report the diagnosis or results associated with the health care services directly to another health care provider, who provides the products or reports to you. We may use or disclose your protected health information that was created or received in emergency treatment situation, to carry out treatment, payment, or health care operations if we attempt to obtain your consent as soon as reasonably practicable after the delivery of such treatment.

We may disclose your protected health information without your authorization in the following circumstances: a) for public health activities, such as controlling communicable diseases, reporting child abuse or neglect, to monitor or evaluate the quality, safety or effectiveness of FDA-related products or services, b) for reporting victims of abuse, neglect or domestic violence, c) for health oversight activities, such as overseeing government benefit programs, d) in response to judicial or administrative orders, such as subpoenas, e) for law enforcement purposes, such as mandatory reporting of certain types of wounds, or identifying or locating individuals, f) for certain research purposes, g) to avert a serious threat to the health or safety of an individual or the general public, and h) for selected governmental function, such as national security. In each of these situations we will keep records that explain our attempt to obtain your consent and the reason why consent was not obtained.

We are required to disclose your protected health information: a) to you upon your request; and b) to the US Department of Health and Human Services (“DHHS”) when DHHS investigates to determine whether we are complying with federal law.

We may disclose your name, your location in our facility, your general condition and your religious affiliation, if any, in our facilities directory, unless you object verbally or in writing.

In all other circumstances we must obtain your authorization to use or disclose your protected health information. You will be required to sign an authorization form which permits us to use and disclose your protected health information for certain purposes, and we may not condition the delivery of medical treatment to you on your providing the requested written authorization. You have the right to revoke our authorization in writing as long as we have not acted in reliance on the authorization.

You have the following rights with respect to your protected health information:

- 1) The right to request restrictions on our use and disclosure of your protected health information for treatment, payment or health care operations. If we agree to any restriction, then we cannot violate that restriction except in the case of emergency treatment. However, we are not required to agree to any restrictions.
- 2) The right to request in writing and to receive confidential communications of your protected health information by alternative means (such as by mail or email) or alternative locations (such as your office or business workplace).
- 3) The right to request in writing access to our office to inspect and copy your protected health information. Except in cases where the protected health information is not maintained or accessible on-site, we will act on a request for access no later than thirty (30) days after we receive our request.

- 4) The right to request in writing that we amend your protected health information. Your request must contain the reasons to support the requested amendment. We will act upon your request within sixty (60) days after we receive your requested.
- 5) The right to receive an accounting of all our disclosures of your protected health information in the six years prior to the date of your request, except for disclosures (A) to carry out treatment, payment and health care operations, b) to you, c) for your directory or to persons involved in your care, d) for national security or intelligence purposes, e) to correctional institutions or law enforcement officials, 1) pursuant to any written authorization that you give to use, or g) that occurred prior to April 14, 2003.
- 6) The right to request and obtain from us a paper copy of this notice. If you believe that we have violated your privacy rights, then you may file a written complaint with Carolinda T. Myers-Murphy, MS CCC\SLP who is our privacy officer. You may also file a complaint with the Office for Civil Rights of the DHHS. Your complaint must: a) be in writing, either on paper or electronically, b) name the company and describe the acts or omissions you believed to be in violation of the privacy rules, c) be filed within 180 days of when you knew or should have known that the act or omission complained of occurred unless the time limit is waived by the DHHS for good cause shown. The complaint may be sent to : Office of Civil Rights, US Department of Health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco,, CA 94102. We will not retaliate against you for filing a complaint. If you wish to obtain additional information about any of the matters discussed in this notice, you may contact Carolinda T. Myers-Murphy MS CCC\SLP at (808) 596.0099.

This notice is effective as of November 11, 2009.

Signature of Patient and / or Guardian

Date

Printed Name of Patient and/or Guardian

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures: I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health care information for directory purpose.
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature of Patient and / or Guardian

Date

Printed Name of Patient and/or Guardian

PERMISSION FOR EXCHANGE OF INFORMATION, RECEIPT OF HIPPA

I give permission to exchange medical information, either written or by phone, between my providers of medical and therapeutic services (or those of my child), as well as insurance providers. I understand that the purpose of this exchange is to allow for coordinated services between these providers. I have received the HIPPA information and understand its contents in its entirety.

Signature of Patient and / or Guardian

Date

Printed Name of Patient and/or Guardian

PERMISSION TO USE FILES FOR RESEARCH OR PRESENTATION

I give my permission for use of photographs and records made in the process of examination and treatment, to be used for the purposes of research, education and publication in professional journals.

Signature of Patient and / or Guardian

Date

Printed Name of Patient and/or Guardian

Success of Therapeutic Program

“It must be noted that successful completion of the myofunctional therapy program is dependent upon patient desire, good attitude and self-discipline. Parental involvement and encouragement are important and necessary. Only the dedicated participant and cooperation of the patient can guarantee effective swallowing and resting posture results.”

Airway Problems and Their Affects

In order to be successful in this program, the patient must achieve closed mouth resting posture. A clear airway is necessary in order to reach this goal. Patients who have allergies or related nasal airway problems present a high risk that goals will not be attained or may require additional visits to do so.



725 Kapiolani Blvd. #206
Honolulu, HI 96813
(808) 596-0099
www.speechsolutionshawaii.com

RELEASE AND HOLD HARMLESS

I do hereby release and agree to indemnify, protect and hold harmless, Speech Solutions; LLC and its therapists and volunteers, and all private persons or organizations providing services for Speech Solutions; LLC from any claim or liability whatsoever, including, but not limited to, personal injury, death, property damage, court costs, attorney fees and interest, however caused, including the negligence of Speech Solutions; LLC, as a result of the clients participation in activities.

Signature of Patient and / or Guardian

Date

Printed Name of Patient and/or Guardian

POLICY :: PARENT PRESENCE DURING SPEECH THERAPY SESSIONS

Infants and toddlers with impairments requiring speech therapy also require an alliance between the parents and therapist. Most therapy sessions include demonstrations of techniques to parents so that they can follow through with observed and recommended activities. Your child requires your assistance in order to progress.

If you work full-time and have a regular child care provider, you may provide permission for your child care provider to be present in your place for some of the speech therapy sessions.

We will make every effort to schedule sessions for a time that is convenient to one or both parents and when your child is most ready to work.

We are not affiliated with a Home Health Care Agency and so if your child receives Home Health Care nursing services, you should understand that we do not have a contractual relationship which would allow us to extend services through nurse care providers who are not related to your child. Nurse care providers are certainly welcome to be present and observe therapy sessions and they can follow through with any recommended activities that you request. Nurse care providers cannot be a substitute for your presence.

We understand the challenges related to meeting scheduled appointments. If you cannot be present for you child's speech therapy session please cancel your appointment within 24 hours of the scheduled time, and please refer to our cancelation policy to see how this may affect you.

You may call and leave a message at (808) 596-0099

I have read and understood the policy regarding parent's presence during speech therapy sessions.

Signature of Patient and / or Guardian

Date

I give _____ permission to attend speech therapy sessions with my child when neither of his/her parents are available to attend. Speech Solutions, LLC has my permission to share any relevant medical information necessary to provide service and instruct my representative in home exercise programming.

Signature of Patient and / or Guardian

Date

Printed Name of Patient and/or Guardian

Initial Screening Fee	\$55.00 per screening. An initial consultation is warranted to determine what type of evaluation would be most appropriate for you or your child.
Speech/Language Evaluation Fee	\$62.50 / 15 minute segment per Senior Speech Pathologist \$50.00/ 15 minutes segment per Staff Speech Pathologist
Orofacial Myology Evaluation Fee	An initial evaluation may involve some or all of the following elements: <ul style="list-style-type: none"> • The taking of a detailed case history • Counseling (according to the patients emotional needs) • Determination of options for ongoing management following assessment • Consideration and implementation of appropriate treatment • Administration of standardized clinical assessment or an empirical clinical assessment • Assessment of the ability of the patient to communicate at the persons school or workplace • Evaluation and analysis of the assessment results • Time spent writing an evaluation report
Assessment Report	\$49.00 for an electronic or hard copy of the assessment report
Private Speech/Language/OFM Therapy Fee	\$125 / session with a Senior Speech Pathologist \$110 / session \$ 69 / OFM therapy session
Group Therapy Rates	\$60 / per student/hour: Group of 2 \$50 / per student/hour: Group of 3
Travel Fee	\$1.25 per minute of travel time from the therapist's current location to your location and back. Travel may be used for the purposes of <ol style="list-style-type: none"> a) Case conference, or b) A home, hospital, or worksite visit, or c) Therapy/consultation where the patient is otherwise unable to attend sessions in the speech therapy clinic or rooms.
Consultation Fee	Meetings or phone conferences will be charged a consultation fee at the speech/language therapy rate. This includes but is not limited to meetings with a client or responsible party, outside therapist, school representative, physician and/or attorney/advocate, during testimony at legal proceedings. Time spent reviewing any outside documentation will be charged at the therapy rate.
Paperwork Fee	Any paperwork requested by the client will be charged a paperwork fee at the speech/language therapy rate. (i.e., may include but not limited to time spent writing an evaluation report, or progress report).
Bad Check Fee	\$45.00 in addition to your last statement fee will be applied.
<p>** All charges and rates detailed above are subject to review. Therapy Sessions are approximately 45-60 minutes long depending on an individuals' ability to tolerate the goals targeted.</p> <p>* There is no direct billing to insurance companies except for Tri-Care patients. Payment is conducted in advance by Credit Card only on the 1st of each month prior to therapy. An official invoice will be issued before payment is collected and can be submitted by the client for reimbursement through an individual's health plan coverage.</p>	

PATIENT RESPONSIBILITIES

Patients (or legal guardians/caregivers) will automatically be charged on their credit card on the 1st of each month for their scheduled therapy sessions. If a patient cancels a therapy session, they have within the current billing cycle to make up the therapy session without penalty, and is subject to availability. (i.e., if you cancel an appointment in September, it must be made up before October 1st). If a patient cancels less than 7 days prior to the 1st of the month, they will have 7 days to reschedule a missed appointment. (i.e., if you cancel on the 9/28, then you will have until 10/5 to reschedule). Parents should notify us of any known schedule conflicts before the 1st of the month in order to avoid a charge. **If a patient is unable to reschedule before the next billing cycle, the amount applied towards the canceled therapy session is not reimbursable.** I further understand that Speech Solutions reserves the right to change our therapy schedule should we miss 3 appointments in a 1-month period. A patient (or legal guardian/caregiver) will be responsible for all uncovered costs, including but not limited to: speech/language services and any additional charges explained above. I have read, understood and agree to the terms and policies of Speech Pathology of Hawaii; LLC (DBA: Speech Solutions).

Signature

Date



AGREEMENT OF FINANCIAL RESPONSIBILITY

The purpose of this form is to help Tri-Care/Tri-West/UHA members make an informed choice about whether or not they want to receive the services, items or services listed below, knowing that they might have to pay for the services themselves. Members must be given ample opportunity to review this form and discuss it, as well as service options with his/her provider.

Notice from Provider (Speech Pathology of Hawaii) to Member (You)

Insurance will only pay for services that meet their payment determination criteria as set forth in your health plan. If your insurance carrier determines that a particular service or day of service does not meet their payment determination criteria, your insurance will not pay for that service. We believe that, in your case, your insurance probably will not pay for these reasons to include but not limited to the following:

Service	Initials	Estimated Charges
<i>A particular day(s) of service that does not meet their payment criteria</i>		<i>Please refer to the explanation of fees to determine estimated charges</i>
<i>A particular day(s) of service that isn't paid in full by you insurance carrier (i.e., payment reduction fees)</i>		
<i>Transportation Fees</i>		
<i>Consultation Fees</i>		
<i>Paperwork Fees</i>		
<i>Materials Fees</i>		
<i>Cancellation Fees and Policies</i>		
<i>Screening Fees</i>		
<i>Group Services</i>		
<i>Bad Check Fees</i>		

Speech Pathology of Hawaii
DBA Speech Solutions

Effective November 8, 2012

Cancellation Policy

Appointment cancellations should be made by the 1st of the month (i.e., cancel a January 15th appointment before January 1st). Cancellations made after the 1st of the month AND not rescheduled before the next billing cycle (the 1st day of the following month), will be subject to a \$70 cancellation fee plus GET (\$73.30). This fee supersedes that of the standard cancellation fee on the Explanation of Fees and will be waived if you provide a Doctor's note for the date of the cancelled appointment. Please see the Explanation of Fees form for more details.

Beneficiary Agreement

This agreement is between me (the insurance beneficiary whose signature appears below) and my provider, whose name is Speech Pathology of Hawaii (DBA Speech Solutions), LLC. I have been notified by my provider that he or she believes that, in my case, my insurance will probably not pay for the services or items identified above. If my insurance denies payment, I agree to be personally and fully responsible for payment of the services, items, or laboratory tests for which the provider's estimated charge is show on the explanation of fees. I understand that the charge above is only an estimated charge and may not be the actual charge or total amount I will be responsible for.

Beneficiary: Please write your initials in the boxes above for those services in which you agree to pay the provider.

I understand that for each service listed above, my insurance may not pay for the service because the service may not meet their payment determination criteria. By signing below, I request that each service which I have initialed in the boxes above be rendered. If my insurance carrier denies payment for the service, I agree to pay my provider in full for each service.

Printed Name of Beneficiary or Authorized Representative

Date

Signature of Beneficiary or Authorized Representative

CREDIT CARD AUTHORIZATION

Please complete the following to authorize the charge to your credit card

NAME ON CARD: _____

MAILING ADDRESS: _____

CARD NUMBER: _____

TYPE OF CARD: _____
(NOTE: We accept MasterCard, Visa, and Discover, NOT AMEX)

EXPIRATION DATE: _____

SIGNATURE: _____

DATE: _____

TELEPHONE #: _____

COMMENTS: _____

TRICARE AUTHORIZATION

For patients with Tricare insurance only. Please fill out the following information so we can bill Tricare for services.

SPONSOR SSN: _____

CHILD'S BIRTHDATE: _____

*Note: We require a paper copy of your Tricare authorization, made out to Speech Pathology of Hawaii, in hand **before** services can be rendered. This can either be faxed to 1-888-331-0723, or emailed to admin@speechsolutionshawaii.com. We reserve the right to cancel any evaluation or therapy session if prior authorization is not secured. For patients with Tricare Standard, please talk to our billing department prior to your evaluation to confirm self-referral status. Any services not paid are the responsibility of the parent / patient. If the evaluation is denied by Tricare, you will need to follow up with Tricare directly to request payment.*