2024 EMERGENCY CONTACT AND MEDICAL INFORMATION

Patient Information Section:	
Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Parent's/Guardian's Name**:**	Parent's/Guardian's Name**:**
Home Phone:	Home Phone:
Mobile Phone:	Mobile Phone:
Email:	Email:
Alternative Emergency Contacts	
Primary Emergency Contact:	Secondary Emergency Contact:
Relationship:	Relationship:
Address:	Address:
City, State Zip Code	City, State Zip Code
Phone Number:	Phone Number:

Patient's Medical Information Section:
Physician's Name
Hospital/Clinic Name
Address
City, State, ZIP Code
Phone:
Allergies/Special Health Considerations:
Siblings (name, age, birthday):

I authorize permission to listed contacts below to take my child from the facility. This waiver applies in the event that neither parent/guardian can be reached in case of an emergency.

Authorized Person Name: _____ Phone Number: _____

Relationship to patient: _____

Authorized Person Name: _____ Phone Number: _____

Relationship to patient: _____

2024 Cancellation Policy

Dear Clients,

Thank you for choosing IICA Speech for your speech & language, feeding, and occupational therapy needs. Your evaluating therapist will prescribe a specific dosage (frequency of appointments) required to make progress. Our goal is to help you maintain consistent treatment in order to maximize the benefits of your treatment program.

Showing up on time for all scheduled appointments is your most important job. We take this subject seriously because it can determine if you are successful in treatment. The policy outlined below addresses cancellations, no-shows, and attendance.

1. We require at least 48 hours notice to cancel an appointment, and we require cancelled sessions to be rescheduled within 2 weeks of the cancellation. It is your responsibility to provide alternative availability to reschedule the session upon cancellation. If your regular therapists are not available, you will be scheduled with a qualified therapist who can accommodate your availability. **Please note sessions cancelled same day may automatically be charged our cancellation fee.**
2. If we are not able to reschedule your cancelled session within 2 weeks, there will be a $95 cancellation fee charged to the patient's account that will be your responsibility. **Cancellation fees are not covered by insurance.**
3. A "no show" appointment occurs when we do not receive notice of cancellation for a session. No show appointments are automatically charged to cover the therapist's prep time. **Your second "no show" will result in being removed from the schedule and a flex schedule option may be presented to you to help find convenient appointment times for you.**
4. We require 85% attendance to remain on the schedule, 3 consecutive cancellations or more than 15% of sessions being cancelled within a 4-week period will result in being removed from the schedule, and a flex schedule option may be presented to you. More than 2 weeks of cancellations will result in a temporary hold. Upon your return you may contact the front office with your availability for sessions. Please note your previous therapist(s) and time slots may not be available.

By signing this document, you understand and agree to our policy as it is written above.

Signature _____ Date _____

2024 CONSENT TELEHEALTH SERVICES (video visits)

1. I understand that my health care provider wishes me to engage in ongoing telehealth visits or may request occasional telehealth visits.
2. I understand that ASHA's position on telehealthservices is that they are as beneficial as in person appointments.
3. I understand that telehealth services are considered medically necessary, and I am expected to maintain the recommended level of frequency of appointments outlined in my most recent evaluation.
4. My healthcare provider explained to me how the video conferencing technology that will be used will not be the same as a direct client/health care provider visit since I will not be in the same room as my provider.
5. I understand that a telehealth service has potential benefits including easier access to care and the convenience of meeting from a private location of my choosing that is conducive to learning.
6. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth visit if it is felt that videoconferencing connections are not adequate for the situation.
7. I will have a direct conversation with my provider during our first telehealth session, during which I will have the opportunity to ask questions regarding this procedure. My questions will be answered and the risks, benefits, and any practical alternatives will be discussed with me in a language in which I understand.
8. I understand that our "in clinic" payment policies apply to telehealth visits.
9. I understand that IICA Speech utilizes Zoom which is HIPAA compliant.
10. I understand that my sessions will not be recorded without my consent.
11. I understand that my medical condition and information will remain confidential.

CONSENT TO USE THE ZOOM PLATFORM FOR TELEHEALTH SERVICES

1. Zoom is NOT an emergency service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I will be in direct, virtual contact through the telehealth service, Zoom does not provide any medical or healthcare advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by Zoom platform facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice, or care
4. I do not assume that my provider has access to any or all the technical information in the telehealth by Zoom service – or that such information is current, accurate or up to date. I will not rely on my health care provider to have any of this information in the telehealth services.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment, nor will I videotape or audiotape any portion of our sessions for any reason.

BY SIGNING THIS FORM, I CERTIFY:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s)
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction

Patient name:_____ Date: _____

Relationship to patient: _____

Signature: _____

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2024 CREDIT CARD AUTHORIZATION FORM

Patient name:_____ Date: _____

The following information is REQUIRED. Our clinic requires a non-HSA/FSA card on file that can be used for medical and/or administrative fees.

CREDIT CARD TO BE CHARGED FOR PAYMENT

☐ MasterCard ☐ VISA ☐ American Express ☐ Other (write here)

Card Number		Expiry Date	
Cardholder		CVV Code	
Billing Address			

The following information is NOT REQUIRED. HSA/FSA cards can only be used for medical expenses.

If you would also like to have an HSA/FSA card on file in addition to a Credit/Debit card, please fill out the information below.

HSA/FSA CARD INFORMATION

☐ HSA ☐ FSA

Card Number		Expiry Date	
Cardholder		CVV Code	
Billing Address			

By signing below, I agree to the following:

1. I accept financial responsibility for all services provided.
2. I am responsible for keeping my account current regardless of 3rd party payer assistance.
3. I agree to pay denied insurance claims when notified by IICA within 7 days. I agree to allow this credit card to be used for payment on denied claims.
4. I have received a copy of IICA's Privacy and Health Insurance Policies and Procedures.
5. I am the legal guardian or parent with the lawful right to make decisions regarding the health and welfare of the child to be seen at IICA.
6. I agree to pay for sessions missed with less than 48 hours' notice, or emergency cancellations missed with less than 24 hours' notice, unless made up within 2 weeks.
7. I agree to pay for "no show" appointments (notice is not provided prior to scheduled appointment).
8. I agree to keep this card on file and utilize it for delinquent charges, late cancellations, and account balance.
9. Please present your card to the front office staff for verification purposes.
10. Credit card payments for ongoing appointments require the physical card to be present and swiped.

Card Holder Name	Date

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2024 HEALTH INSURANCE REIMBURSEMENT STATEMENT

If you would like to utilize your health insurance, here's what you should know:

Speech Therapy, feeding therapy, and occupational therapy are often listed as reimbursable services through medical insurance companies; however, policies often do not cover pediatric therapy services unless the therapy is due to a "medical condition." Autism and similar diagnoses are exceptions. These diagnoses are covered under California AB: 88 Mental Health Parity Law. Please note, "self-funded" policies are different. Pediatric therapy benefits for ASD are at the discretion of the insurance company and may be exempt from coverage on self-funded plans. If you are not sure if you have a "self-funded" plan, contact your HR representative.

Some plans include speech therapy, feeding therapy, occupational therapy, physical therapy, and/or respiratory therapy under the same benefit category. In these cases, the insurance company may place a combined limit on number of visits (hard cap) or apply "cascade payments". If you have utilized any of these services during a calendar year by a provider other than IICA Speech, or if you add any additional services throughout the year, we must be alerted. It is your responsibility to pay for services incurred after your benefits have been exhausted or for additional charges incurred due to failing to inform our office.

Your insurance policy is a contract between the patient and the insurance company. We may bill as a courtesy to our patients as long as insurance companies are paying in a timely manner. You are ultimately responsible for payment of services. If, for any reason, treatment is denied by your insurance, you will be charged for the denied services. IICA will not be held responsible for any reason for any errors on authorizations for services.
If we are "out of network providers", we are not obligated to discount or negotiate rates. In these cases, you may be liable for payment to IICA Speech. Should your insurance company lag or deny claims, we will charge your credit card on file and provide SuperBills, which can be used to seek reimbursement on your own behalf from your insurance company.

We are required by law to collect deductibles, copayments, coinsurance, etc. We are not permitted to waive or reduce copayments or deductibles for any reason. We also require an alternative form of payment on file before your first appointment (VISA or MC) for all insurance and private pay clients to cover unpaid deductibles, late cancellations, no shows, childcare charges, and unpaid invoice balances.

In the event that disputes between primary, secondary, and/or dual coverage arise, patients are financially responsible for all charges. IICA does not bill secondary insurance. Patients need to pay for deductible/copay/coinsurance etc. at the time services are rendered.
All EOB balances, copayments, and known deductible amounts must be paid at the time of service. You will be provided with a receipt as proof of payment.

Some policies send payments directly to families. When this happens, it is your responsibility to bring the insurance check and a personal check to IICA at the time of your next appointment or within seven days of receipt. Accompanying paperwork (EOB) must also be submitted.

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If you receive insurance checks directly What will the check(s) look like?
The check will come from the insurance company and will come with an Explanation Of Benefits (EOB).

Who will the check(s) be made out to?
Checks will be made payable to the patient/parent(s) who received the services.

What is this money for?
This money is to be paid to the provider for services rendered in our office.

Why were the check(s) sent to me?
Some insurance companies may send checks directly to the member when the member is going to an out-of-network provider. In most cases the amount of the check is a portion of the amount due to the provider. The insurance company has paid their portion, and you will be responsible for your portion.

What should I do with these check(s)?
Please cash the check and write a personal check made payable to "Integrated Intervention for Children With Autism" or "IICA".

Please send the check with the EOB to our office in a timely fashion or no later than your next scheduled appointment. We will process the check(s) accordingly, and if any further payment is due to our office, we will send you an invoice/statement. We must receive the EOB with the check.

What if I do not send the check(s) to your office?
You will be billed for the full amount of the service. Keeping this money is insurance fraud, and it's your responsibility to make sure we receive payment for services rendered upon receipt of check(s).

I have read and understand the above explanation of payment.

Print Name *Date of Birth*

Signature

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2024 PRIVACY POLICY

The passage in August 1996 of the Health Insurance Portability and Accountability Act (HIPAA or the Privacy Rule) occurred, in part, to improve the efficiency and effectiveness of the healthcare system by standardizing the transmission of certain administrative and financial information and by protecting the privacy and security of personal health information.

The Privacy Rule essentially controls the use and disclosure of what is known as the Protected health Information (PHI). It affords the patient greater knowledge of the content of their medical records and how that content (PHI) is used. The Privacy Rule enables the patient to control the disclosure of his or her protected health information to certain entities.

The Security Rule focuses on requirements for covered entities (including medical practices) to protect and safeguard the confidentiality of medical information. The Security Rule specifically addresses the transmission, storage, and receipt of data.

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of formalized testing will be available in your medical record to all help professionals who may provide treatment or who may be consulted by IICA staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, credit card companies that you may use to pay for services, or collection agencies. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of IICA. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointment Reminders. Your health information may be used by our staff to send you appointment reminders.

Other uses of your PHI may require your authorization. Disclosure of your health information or its uses for any purpose other than those above may require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your PHI.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your PHI.
- The right to amend or submit corrections to your PHI.
- The right to receive an accounting of how and to whom your PHI has been disclosed.
- The right to receive a printed copy of this notice.

IICA Duties

We are required by law to maintain the privacy of your PHI and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect PHI

You may generally inspect or copy the PHI that we maintain. As permitted by federal law, we require that requests to inspect or copy PHI be submitted in writing. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Amy Haught MA, CCC-SLP
IICA Speech Founder+ CEO
Email: amy@iicaspeech.com
Phone: 408-437-8864

Patient's Name		*Date of Birth*	
Parent's Name		*Parent's Signature*	

2024 REQUESTING CLINICAL NOTES & REPORTS

Insurance companies often require an initial speech and language assessment. They do not allow us to submit your IEP/IFSP. Doing so will often trigger a denial on the grounds that we are billing for "educationally relevant services" rather than "medically necessary services". They may allow us to submit other private speech and language assessments if they are no older than 12 months. Insurance companies may require a formal evaluation each year. If we have appropriate outside reports, our first visit may be used as a diagnostic treatment/evaluation session to gather information from reports, observation, and client input and formulate a treatment plan.

Progress notes requested directly by the patient will not be reimbursed by insurance. The patient will pay for them at the time of request, at a rate of $150.00 per report. Reports will be distributed 2 weeks after receiving your written request.

Assessment reports are typically distributed to the family, PCP, and insurance company within 2 weeks following the final completion of an assessment.

We provide proof of payment at time of service. Additional statements, invoices etc. requested by the patient will be processed within 2 weeks and will incur an administrative fee of $35.00.

Print Name	*Date*

Signature

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