GATEWAY COMMUNICATIONS, PLLC
SPEECH AND LANGUAGE THERAPY

Welcome to Gateway Communications, PLLC!

Thank you for choosing Gateway Communications, PLLC to help your child achieve speech and language goals. We realize that you have options regarding speech therapy for your child and we are happy you selected us to assist your child in achieving these goals. The new client paperwork packet includes important information about the therapeutic process including insurance, financial, attendance, and privacy policies. Please take time to fill out the client history form as completely as possible to enable a most accurate treatment plan. Additionally, if your child has had any recent assessments completed by another health care professional including but not limited to an Audiologist, ENT, another Speech Pathologist, etc., please provide copies so that we are able to get the whole picture of your child.

Dear Parent(s),

In order to begin therapy services, please complete and submit the following information:

1. A copy of the front and back of the policy holder's insurance card.
2. A copy of the front and back of the patient's insurance card.
3. Signed copies of the following forms:
   - Informed Consent for Speech Therapy (your permission to provide services)
   - Payment Policy & Agreement
   -Insurance Payment Information
   - Cancellation & No-Show Policy
   - Consent for Release of Information
   - Acknowledgement of Receipt of Privacy Practices
   *Please keep the "Notice of Privacy Practices" for your records but sign and return the last page titled "Acknowledgement of Receipt of Privacy Practices"
4. Complete the Case History Form*
   **Please complete the Case History Form to the best of your ability. This will help us better understand the needs of your child.*

You may fax or mail the completed and signed initial paper work to Gateway Communications, PLLC.

Office Address:
Gateway Communications, PLLC
351 Wagoner Drive, Suite 341
Fayetteville, NC 28303

Fax: (844) 833-5682
Email: therapy@gatewayspeech.com

You can also return the completed packet to your child's school. Please contact us so we will know when to go to the school and pick it up. Feel free to call/text us at 910-447-9555.

We look forward to working with you to facilitate and improve your child's speech and language skills. Please do not hesitate to call us at (910) 447-9555 if you have any questions about the required forms or about our speech therapy services in general.

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INFORMED CONSENT FOR SPEECH THERAPY

I, _____, the parent/legal guardian of

_____, hereby request and consent for Gateway Communications, PLLC to perform evaluations, treatment, and care for my child as prescribed by a physician and/or recommended by a speech-language pathologist.

Evaluations: Evaluations will be conducted every 6 months. Evaluations typically last about 1 hour. It is possible for your child's evaluation to be completed over the course of two 30-45 minute sessions. Results of the evaluation will be sent to the referring doctor and insurance companies as standard protocol.

Treatment/Sessions: Sessions typically run 30 minutes. For home-based therapy sessions, a parent or designated adult (e.g., babysitter, nanny, grandparent) must be in the home for the duration of the session.

Gateway Communications, PLLC reviews clients and other files for the purpose of ensuring that we provide high quality services Speech Language Pathologists adhere to the guidelines set forth by the American Speech and Hearing Association (ASHA) and the North Carolina Board of Examiners for Speech-Language Pathologists and Audiologists. In addition, Gateway Communications SLPs are licensed in the state of NC. Licensed SLPs supervise Speech Pathology Assistants, Clinical Fellows (new graduates), and students. We abide by the code of ethics as outlined by ASHA.

Comments, Questions, Complaints: All feedback is encouraged! Gateway Communications, PLLC strives to be the best in speech/language therapy. Positive comments are always welcome, and information about things we can do better is very valuable. If there is something you are not happy with, please bring it to our attention. Every effort will be made to make the necessary changes to make your experience positive. There will be no retaliation for complaints.

Changes in Policy: Gateway Communications, PLLC reserves the right to make policy changes at any time. Clients will be informed of any policy changes prior to their implementation.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist. I consent and authorize Gateway Communications, PLLC to administer treatment under the direction and supervision of a certified Speech-Language Pathologist.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Name (printed)

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PAYMENT POLICY & AGREEMENT

Gateway Communications, PLLC is currently an in-network provider for Medicaid. If your current insurance provider is Medicaid, benefits will cover 100% of the payment for the evaluation and therapy. **Gateway Communications, PLLC** will directly bill Medicaid for evaluations and therapy.

Gateway Communications, PLLC is currently an in-network provider for Tricare. We will proceed with billing Tricare for services rendered. With this billing option, you may be responsible for a co-pay which will be billed on a weekly basis. You will be responsible for any deductibles that apply. Furthermore, should your insurance carrier deny or fail to pay your claim, or fail to pay your claim in full, you as the parent/guardian will be responsible for payment of the services and/or the payment balance which was not covered by insurance.

We also accept private/out-of-pocket payment. It is the responsibility of the parent or guardian to file all non-Medicaid, non-Tricare, insurance claims if you so choose. **Gateway Communications, PLLC** will provide all clients with a detailed invoice for services rendered that can be submitted for insurance claims by the parent and/or guardian. **Gateway Communications, PLLC** will also provide additional information on services rendered upon request should your insurance carrier request more information beyond the invoice. Please note that it is the responsibility of the parent and/or guardian to contact their insurance carrier to determine the required documentation for filing insurance claims.

Patients will be billed on a weekly basis for services rendered. Payment is due within 7 days of invoice receipt. Failure to make any payment will result in your child's services being put on hold until payments are received and your account is paid in full. If you pay by check and that check bounces, you will be charged a $25.00 processing fee. Please make checks payable to Gateway Communications, PLLC.

A 1.5 % interest charge will be added to 30-days past due accounts. Accounts over 90 days past due will be turned over to a reputable collections agency. If you terminate therapy for any reason, you will be responsible to pay all fees, co-pays, coinsurance and deductibles immediately.

Parents and/or guardians must also notify **Gateway Communications, PLLC** if your child's physician or insurance coverage changes.

***Families are responsible for checking their financial responsibilities with their insurance carrier. It is not the responsibility of Gateway Communications, PLLC to provide benefit information. Should actual coverage be different than what was quoted by your carrier, contact your insurance carrier directly. Payment is still expected by Gateway Communications, PLLC, we will not wait for insurance to make adjustments. Families will be responsible for all payment not covered by insurance. ***

As the parent or guardian, I have read the above information and understand **Gateway Communications, PLLC's** Insurance Policies and Authorization to Release Information. I accept all terms and conditions.

_____ _____

Parent/Legal Guardian Signature Date

_____

Parent/Legal Guardian Printed Name

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INSURANCE/PAYMENT INFORMATION

Insurance Carrier:
Billing/Claim Address:
Benefit/Eligibility Phone Number:
Policyholder Name:
Plan/Program Name:
ID Number:
Policy Group or Number:

NOTE: Copies of the policyholder's driver's license and insurance card must be provided. You can email/fax pictures of the front and back of insurance card and driver's license or military identification card.

PARTY RESPONSIBLE FOR PAYMENT (Typically Parent/Guardian Information. Must be completed)

Name:	DOB:	SSN:
Address		
Phone:		
Employer Information:		
Company Name:		
Company Address:		
Contact Number:		

I, _____ authorize the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims. I hereby authorize payment directly to Gateway Communications, PLLC of the insurance benefits otherwise payable to me for all professional services. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I have read and understand all of the information provided. The above answers are true and correct to the best of my knowledge. I am responsible of updating any changes that may affect payment including physician and insurance changes.

_____ _____

Parent/Legal Guardian Signature Date

_____

Parent/Legal Guardian Printed Name

GATEWAY COMMUNICATIONS, PLLC
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CANCELLATION & NO-SHOW POLICY

Missed Sessions/Cancellation Policy

Our therapists prepare ahead of time specifically for your session. We request that you notify us 3 hours prior to your appointment if you need to cancel or reschedule. Failure to call or be present for an appointment is considered a missed appointment. **Gateway Communications, PLLC** will charge the patient or the responsible parent/guardian $30 for all missed appointments. **Please note that insurance providers do NOT reimburse for missed appointment charges.** If your child misses 3 or more therapy sessions within a 6-week period, **Gateway Communications, PLLC** reserves the right to place your child's services on hold until scheduling conflicts are resolved. A consistent schedule is pertinent to your child's progress in speech-language therapy. Please help us serve you better by keeping scheduled appointments or calling at least three hours prior to reschedule.

Illness Policy

If your child has a fever, a persistent cough, or a runny nose, please call and cancel your appointment. Because of the close proximity of the therapist to the child's face, it is easy for the virus to be spread. Your therapist needs to see many children over the course of the week and cannot afford to be out sick frequently. A general rule of thumb is that if a child has been on an antibiotic for 24 hours and does not have a fever, is not coughing frequently, and does not have a runny nose, he/she is probably not contagious. We appreciate your understanding and will be happy to reschedule your appointment. We have a 24-hour answering service, so feel free to call us at any hour and leave a message. We appreciate a minimum of a three-hour notice if you are canceling; however, we also understand how illness in young children can occur suddenly, so you will not be penalized with a fee if you call and cancel for sudden illness.

Inclement Weather Policy

For clients that are seen in-home, **Gateway Communications, PLLC** reserves the right to cancel or reschedule appointments in the event of inclement weather. Our goal is to keep our therapists safe on the roads. For clients that are seen in daycares, we follow the same inclement weather policy as Cumberland County Schools and/or your child's school. Many clients keep the same appointment time each week, in which case it is understood that you will be seen at the same time on the following week. I have read and accept all policies pertaining to missed appointments, illness, and inclement weather.

****It might be necessary for your therapist to cancel a therapy session on short notice. Gateway Communications, PLLC will make every effort to make sure you are aware of the need to reschedule and will find a time that is convenient for you to make up the session.*

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

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CONSENT FOR RELEASE OF INFORMATION

Child's Name:_____ Date of Birth: _____

I, _____ (Parent/Guardian) hereby grant Gateway Communications, PLLC to communicate with the following person or agency:

Name of Facility/Clinic	
Name of Physician	
Address	
Phone	
Fax	

Insurance Company	
Phone	
Fax	
Address	

OTHER: (If you would like us to communicate with any other professional/person regarding your child's communication skills, i.e., physical therapist, occupational therapist, etc., please list in the box below)

Name of person	
Name of Facility	
Relationship to patient (teacher, physical therapist, etc.)	
Phone	
Fax	
Address	

Specific information to release (most recent evaluation/treatment plan, discharge summary)

- ☐ **Most recent evaluation summary**
- ☐ **Treatment plan**
- ☐ **Discharge summary**
- ☐ **Other: _____**

Gateway Communications, PLLC may discuss and release to the person or agency (listed above) information including but not limited to: evaluation reports, treatment plans, progress notes and therapy documentation, previous medical history, as well as necessary verbal communication pertaining to the child. This information will be used for diagnostic and treatment planning purposes only. It is my understanding that this information will not be shared with any other entity without my prior knowledge. I further acknowledge that the use of this information is to ensure the best quality of care possible for my child.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Name (printed)

GATEWAY COMMUNICATIONS, PLLC
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Notice of Privacy Practices

Effective Date: 01/01/2017

Your Information. Your Rights. Our Responsibilities.

Privacy of personal information is an important principle to Gateway Communications, PLLC. We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the services we provide. **This notice describes how medical information may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.**

WHAT IS PERSONAL INFORMATION?

Personal information is information about identifiable individuals. Personal information includes information that relates to:

- an individual's personal characteristics (e.g., gender, age, home address, telephone number, insurance information);
- health (e.g., health history, health conditions, health services received by them);
- activities and views (e.g., opinions expressed by an individual, an opinion or evaluation of an individual).

Personal information is different from business information (e.g., an individual's business address and telephone number). This is not protected by privacy legislation.

WE COLLECT PERSONAL INFORMATION: PRIMARY PURPOSES

Like all medical professions, we collect, use and disclose personal information to properly serve our clients. For our clients, the primary purpose for collecting personal information is to provide treatment. For example, we collect information about a client's health history, including their family history, physical condition, function and social situation to help us assess what their health needs are, to advise them of their options and then to provide the health care they choose to have. A second primary purpose is to obtain a baseline of health and social information so that in providing on going health services we can identify changes that occur over time.

WE COLLECT PERSONAL INFORMATION: RELATED AND SECONDARY PURPOSES

Like most organizations, we also collect, use and disclose information for purposes related to or secondary to our primary purposes. The most common examples of our related and secondary purposes are as follows:

To invoice clients for goods or services that was not paid for at the time, to process credit card payments or to collect unpaid accounts.

Your Rights

When it comes to your health information, you have certain rights. *This section explains your rights and some of our responsibilities to help you.*

Get an electronic or paper copy of your medical record

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

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will agree 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 or health care item out-of-pocket in full, you can ask us not to share that information with your health insurer. We will agree unless a law/contract requires us to share that information.

Get a list of those with whom we’ve shared information

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us directly.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. ***We will not retaliate against you for filing a complaint.

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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.:

1. **Treat you**

   We can use your health information and share it with other professionals who are treating you.

   Example: We typically send evaluations, progress reports and discharge summaries to your primary medical care provider.

2. **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 develop your treatment plan and provide individualized services.

3. **Bill for your services**

   We can use and share your health information to bill and get payment from health plans or other entities.

   Example: We give information about you to your doctor and health insurance plan so it will pay for your services.

-Do research

We can use or share your information for health research.

-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 if it wants to see that we're complying with federal privacy law.

-Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

-Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

-Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect. To obtain our most current notice, please visit our website or contact our office.

Our Responsibilities:

- 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: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

DO YOU HAVE A QUESTION?

If you wish to make a formal complaint about our Privacy Practices, you may make it in writing to our office manager. She will acknowledge receipt of your complaint; ensure that it is investigated promptly and that you are provided with a formal written decision with reasons. If you have a concern about the professionalism or competence of our services or the mental or physical capacity of any of our professional staff we would ask you to discuss those concerns with us. However, if we cannot satisfy your concerns, you are entitled to complain to our regulatory body: American Speech and Hearing Association at www.asha.org

Written Statement of Policy Privacy of personal information is an important principle to Gateway Communications, PLLC.
Clients or other individuals we treat may have questions about our services after they have been received. We retain our client information for a mandatory minimum of seven years after the last contact to enable us to respond to those questions and provide these services.

Changes to the Terms of this Notice

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

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

The privacy practices notice contains a patient's rights section describing your rights under the law. Gateway Communications, PLLC is required by law to keep your health information safe. This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

We are required by law to give you a copy of our **Notice of Privacy Practices**. This notice tells you how your health information may be used and shared.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. If this consent is signed by a personal representative on behalf of the patient, complete the following:

By signing this page, you are saying that you have been given a copy of our privacy notice and you consent to our use and disclosure of your protected health information.

Child's Name: _____

Parent/Legal Guardian Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____