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**Little Bean Speech, PLLC**

# ADMISSION AGREEMENT

**Informed Consent for Speech Therapy**

I, , the parent/legal guardian of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , hereby request and consent to Little Bean Speech, PLLC to perform treatment and care for my child as prescribed by a physician and/or recommended in my plan of treatment prepared by Little Bean Speech, PLLC. I acknowledge and agree that a **parent or legal guardian must be in the home during each treatment session**. I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

**Our amazing therapists:** Each therapist holds a NC license to practice from the North Carolina Board of Examiners, has obtained a Master’s Degree in Education or Science and a Certificate of Clinical Competence from the American Speech-Language Hearing Association. In addition, coaching training through the Children’s Developmental Services Agency has been completed. A lead therapist or owner may attend sessions to support clinician skills and to continue team collaboration with all our families and children we serve. Background checks are completed on all therapists prior to beginning employment with Little Bean Speech.

# Authorization for Payment of Services

* **Private pay and private insurance Patients:** I certify that the information given by me in applying for payment from my insurer is correct. I request that payment of authorized benefits be made on my behalf to Little Bean Speech, PLLC. I understand that I will be billed for services rendered by Little Bean Speech, PLLC. I accept responsibility for payment for those services.
* **Medicaid Patients:** I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf to Little Bean Speech, PLLC. I will be financially responsible for any services rendered not paid by Medicaid.

**Appointments:** Please provide 24-hour notice for all cancellations, except under emergency circumstances. **A $25 fee will be charged if sessions are canceled with less than 24-hour notice** unless the cancelation is due to illness, emergencies or inclement weather. If a pattern of late cancellations develops, evaluation of appropriateness of the program will be completed and potential termination from therapy may be considered. If a client accumulates **three no-shows, termination of therapy is warranted.**

**Attendance:** Following the initial evaluation a frequency of treatment will be established. A schedule will be discussed and agreed upon. Changes to the schedule can occur following a conversation with the treating therapist and parent/legal guardian. To maintain our travel schedule, treatment sessions will begin within 15 minutes of the agreed upon session time. Please understand that we travel to many of our clients and may occasionally be late due to circumstances beyond our control. Communication with the family will be provided regarding any late arrivals. Please communicate with your SLP regarding any illnesses that your family may be experiencing. Sessions maybe canceled if your child or a family member is experiencing any signs or symptoms of illness. **We make decisions to maintain our health and the health of the families we treat.**

**Infection Control/Prevention:** By signing this contract, I acknowledge that Little Bean Speech has put in place measures to reduce the spread of the Coronavirus/COVID-19, Influenza, respiratory viruses, etc. I further acknowledge that Little Bean Speech cannot guarantee or prevent the transmission of illness. I voluntarily seek services provided by Little Bean Speech and acknowledge that I am increasing my risk to exposure with face-to-face services. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

**Little Bean Speech will follow these enhanced procedures to prevent the spread of illness:**

**•** Handwashing or hand sanitizer (if SLP does not enter the home) before and after therapy sessions.

• Limiting the number of manipulatives (toys/books) brought into the home.

• Masks-We will continue to follow the center recommendations if your child is being served within an education placement. We respect your request upon home visits as we are entering your home and want to do what makes you feel the most comfortable. Please communicate with your therapist with your preferences. Therapists will mask or cancel sessions if they believe they are at risk for illness.

**Sessions:** Sessions will run either 30-45 minutes based upon agreement. This treatment time includes reviewing the session with a parent or caregiver and discussing home carryover. If a family member is not present (i.e. daycare/school), an agreed upon mode of communication with be chosen to encourage family involvement and caregiver education stated in each plan of care for treatment. For home-based therapy sessions, a parent or designated adult (e.g., babysitter, nanny, and grandparent) must be in the home for the duration of the session.

**Payment:** The client understands that they will be billed for services rendered by Little Bean Speech, PLLC for private pay and for any expenses not covered by insurance. Claims are submitted at the end of each month. Invoices will be issued via email for payment. Please contact Little Bean Speech for additional payment arrangement. Upon request, documentation of therapy services can be provided so clients can request reimbursement from insurance providers or an FSA. Accounts more than 30 days overdue will be subject to a **$20 late fee**. Returned checks will be subject to a

$20 fee. In the event that you do not honor your financial obligations to Little Bean Speech, PLLC and remain delinquent on your account for more than 60 days, services will be terminated.

**Privacy Notice:** Your privacy is very important to us at Little Bean Speech, PLLC . I recommend that you review this Notice of Privacy Policy for important details for maintaining confidentiality. Please communicate to Little Bean if your contact information has changed.

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

**Authorization to Release Information:** I authorize Little Bean Speech to share information, upon request of any of the following: Department of Social Services, the Social Security Administration, the Department of Human Services, any insurance company or when required by law. Information will only be used to provide treatment, payment and healthcare operations.  **I authorize Little Bean Speech, PLLC to receive information from and release information to the following named people or Agency/School District**

# I understand that by signing this authorization:

* + - I authorize the use or disclosure of my individually identifiable health information as described above for the development of my child’s treatment program.
    - I have the right to withdraw permission for the release of my child’s information at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
    - I have the right to receive a copy of this authorization.
    - I am signing this authorization voluntarily and treatment, payment or my eligibility for benefits will not be affected if I do not sign this authorization.
    - I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
    - The information you and/or your child provide during the screening, admission, evaluation, and treatment process is considered confidential by Little Bean Speech, PLLC. This includes, but is not limited to photographs, videos, audio recordings, client records and reimbursement records. Under the following specific conditions, release of information is permitted and/or required by law and professional ethics.
      1. When Little Bean Speech, PLLC has received a signed authorization from you or your legally responsible person. Such authorization may be revoked at any time except to the extent that action based on this consent has already been taken.
      2. When in response to a request made by regulatory agencies.
      3. The client presents a threat of physical harm to either themselves or to other persons and disclosure is made to avert the potential for physical harm.
      4. When Little Bean Speech, PLLC is required by law to report abuse, neglect or exploitation of children.
      5. When in response to a court order.

**Please indicate to whom we are able to share information. Documentation will be shared with your current pediatrician to obtain a physician order for services.**

|  |  |
| --- | --- |
| ***Pediatrician:*** |  |
| ***School/Daycare currently attending*** |  |
| ***Therapy Agency treating your child:*** |  |
| ***Nutrition/GI physician:*** |  |
| ***ABA Provider:*** |  |
| ***Other:*** |  |

All disclosure of information will be documented in the client’s record. In the event that you wish to review your record, you should contact Lauren Stalte. You will need to make a written request for the information you wish to review. You may then request the information to be mailed or faxed to you. Any breach of privacy will be communicated to you within 60 days of any data breach.

If you have any questions regarding our policies and procedures or if you have concerns with your current service provider/therapist. Please don’t hesitate to contact the owner, Lauren Stalte.

**Questions or Concerns** Lauren Stalte, Owner Little Bean Speech, PLLC 5221 Sunset Walk Ln Holly Spring NC 27540 919-710-5174

[Lauren@LittleBeanSpeech.com](mailto:Lauren@LittleBeanSpeech.com)

The undersigned acknowledges receipt of with agreement to the Little Bean Speech, PLLC Admission Agreement, the Privacy/Confidentiality Policy and Little Bean Speech’s Policies and Procedures.

Signature of Responsible Person Date

Relationship to Patient:

# PRIVACY/CONFIDENTIALITY POLICY

Privacy of personal information is an important principle to Little Bean Speech, PLLC. We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the services we provide. We following the standards stated within the privacy rules stated within the Health Insurance Portability and Accountability Act (HIPAA-1996)

# Personal Information Collection:

Like all medical professions, we collect, use and disclose personal information in order to serve our clients. For our clients, the primary purpose for collecting personal information is to provide treatment, complete billing and practice operations. We will use this information to complete the necessary functions to support the therapy process and to support our team clinical development. We will following the minimal necessary standard to only collect pertinent information to ultimately maintain your privacy. Again, this information will be shared if you practiced is contacted by a regulated entity to share information for federal, state or local law, threats/safety, abuse/neglect, appointment communication (contact information used)

# Protecting Personal Information

We have taken the following steps:

* + - Paper information is secured in a locked or restricted area.
    - Electronic hardware is either under supervision or secure in a locked or restricted area at all times. In addition, passwords are used on computers. Paper information is transmitted through sealed addressed envelopes.
    - Electronic information is transmitted either through a direct line or has identifiers removed or is encrypted. We have a BAA disclosure on our electronic medical records.
    - I collect, use and disclose personal information only as necessary to fulfill my duties and in accordance with our privacy policy.
    - Information is not shared without a disclosure signed by the family/responsible party.

# Retention and Destruction of Personal Property

We need to retain personal information for some time to ensure that we can answer any question the client may have about the services provided and for our own accountability to external regulatory bodies. We keep our clients’ files for seven years according to our regulations. We destroy paper files containing personal information by shredding. We destroy electronic information by deleting it and, when the hardware is discarded, we ensure that the hard drive is physically destroyed

Updated October 2024

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**New Client Intake Form**

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|  | **CHILD’S FULL NAME (FIRST,MIDDLE,LAST):** | |  | **NICKNAME (IF APPLICABLE):** |
| **DATE OF BIRTH:** | | | | **ALLERGIES:**  **PRECAUTIONS:** |
| **PARENT’S/CAREGIVER’S NAMES:** | | | | **REFERRED BY:** |
| **ADDRESS:** | | | | **Pediatric Group: PHYSICIAN:**  **Fax#:**  **PHONE#:** |
|  | Street Address: |  |  |
| Suite/P.O box: |  |
| City and State: |  |
| **PHONE NUMBER:** | | | | **MEDICATION:** |
| **E-MAIL:** | | | | **MEDICAID NUMBER:** |
| **RECEIVING ANY OTHER THERAPY SERVICES?**  **SIGNFICANT MEDICAL HISTORY:** | | | | **INSURANCE:**  **POLICY NUMBER:**  **PERSON RESPONSIBLE FOR INSURANCE:**  **DATE OF BIRTH OF PRIMARY INSURED:** |
| **SCHEDULING OF SERVICE:** | | | | **ADDITIONAL INFORMATION:** |