BROWNING SPEECH THERAPY, LLC
6558 W Candice View Cv Herriman, UT 84096
Phone: (801) 493-9690 Fax: (801) 998-8940
Email: bethbrowning@me.com

INTAKE INFORMATION

LEGAL Patient Name: _____

DOB: _____ Male or Female: _____

Parent/Legal Guardian: _____

Cell #: _____ Home Phone: _____

Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Billing Address, if different: _____

Parent/Legal Guardian: _____

Cell #: _____ Home Phone: _____

Email: _____

REFERRAL SOURCE:

Physician Name: _____Phone #_____

Diagnosis: _____

BROWNING SPEECH THERAPY, LLC.

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INSURANCE/PAYMENT INFORMATION: MUST INCLUDE COPY OF FRONT AND BACK OF INSURANCE CARD if you want us to check coverage and bill it. *Copy of insurance cards needs to be provided at initial evaluation.

Insurance Carrier: _____

ID Number: _____

Policyholder Name: _____

Policyholder DOB: _____

Secondary Insurance (if applicable)

Insurance Carrier: _____

ID Number: _____

Policyholder Name: _____

Policyholder DOB: _____

ASSIGNMENT OF BENEFITS

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 Browning Speech Therapy, LLC of insurance benefits otherwise payable to me for all professional services.

_____ _____

Signature of Policy Holder Date

NOTIFICATION: Browning Speech Therapy, LLC, makes every effort to obtain prior authorization with your insurance company. Prior authorization doesn't guarantee payment from insurance. I understand I am responsible for any speech therapy bills that are incurred that my insurance doesn't pay. **Unpaid outstanding balances will be sent to collections.** I understand it is my responsibility to update Browning Speech Therapy of any insurance changes, and I am responsible for any bills that my insurance doesn't pay if I don't inform of changes prior to visits.

_____ _____

Signature of person responsible for payment Date

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HIPAA - Notice of Privacy Practices

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.

Protection of Health Information: Your health information is kept private according to the federal privacy regulations under the Health Insurance Portability and Accountability Act of 1966 (HIPAA) and you are provided with notices of the legal duties and privacy practices within this practice. Your protected health information in information that relates to your past, present, or future health care. This includes your medication history, diagnostic evaluations, and therapeutic services.

Uses and Disclosures of Your Protected Health Information: Disclosure of your health information may occur for health care operations. Examples of operations in which protected health information disclosures may occur include insurance and billing, management, financial or quality assurance audits, law enforcement purposes, education, referring to other services, and receiving information from other professionals that may have treated you in the past. Your protected health information may be used for treatment purposes inducing provisions, coordination or management of services. Some other examples of disclosures include the following:

- Communicating via text and/or email
- Messages may be left on your answering machine regarding your appointment or to request that you contact this office
- Medical records may need to be transferred to another location
- Disclosures may also be made to student observers or therapists who participate in health care operations and commit to respect the privacy of your health information

Your Rights Regarding Your Health Information: You have the right to review your health information which might include intake information, evaluation, session notes, goals, and progress notes. For all other purposes beyond those listed above, your written authorization will be required to use, disclose, or restrict your protected health information. Your authorization can be revoked at any time except to the extent that we have relied on the authorization. Revocations must be in writing. You may also initiate the process for your information to be sent to someone else through the use of an authorization form or written request. To request further restriction or disclosure, you must submit a written request that explains what information you want restricted, how you want the information restricted, and from whom you want the restriction to apply.

Complaints: If you believe that your privacy rights have been violated, you may submit a complaint to this practice or to the U. S. Department of Health and Human Services. To file a complaint with the practice, submit the complaint in writing. You will not be penalized or retaliated against for filing a complaint and your identity will be kept confidential.

I have received and understand HIPAA. Please print, sign, date this form and return to Browning Speech Therapy.

Print name: _____

Signature: _____

Date: _____

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ATTENDANCE POLICY INFORMATION

Sickness / Attendance Policy

Please cancel if your child has diarrhea, is throwing up, has a fever, or colored discharge from nose. 24 hour notice is requested, if possible. Our therapists will cancel if they have these symptoms so as to not spread it to you and your family. Cancellations other than sickness or emergency (i.e. death in family) must be within 24 hours notice or you will be charged. Please note that No Show fees are not covered by insurance.

In addition to the above, if anyone in the child's household is sick with a fever or other symptoms, the session must be canceled as soon as possible. Speech Therapy will not resume until 48 hours after the fever has gone without the use of medication. If the therapist shows up and has to cancel a session due to anyone in the household showing symptoms, you will be charged for the session at the full rate.

Print Name: _____

Signature: _____

Date: _____

No-Show / Late Cancellations

Excessive cancellations as determined by Browning Speech Therapy, LLC (BST) may result in termination of services.

is when a patient doesn't show up at the scheduled appointment or cancels within 24 hours. BST understands that life happens so you will not be billed the 1st time this happens. The 2nd time, you will be charged 1/2 price of the private pay rate. Even if we normally bill your insurance, this will not be billed to your insurance and it will be your responsibility to pay. The 3rd time and after that, you will be billed the full private pay rate.

Print name: _____

Signature: _____

Date: _____

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Insurance

*Browning Speech Therapy, LLC, office calls your insurance to check coverage for speech therapy for the particular diagnosis associated with your child's delay. Every effort is made to get prior authorization from your insurance company. We cannot guarantee coverage, we recommend checking your coverage with your insurance company prior to starting services. It is patient/parent responsibility to get a copy of the front and back of the insurance card, policy holder, and policy holder's date of birth to bethbrowning@me.com. It is also your responsibility to let the office know of any insurance policy changes.

*Even though we make every effort to get confirmation and/or prior authorization, **if insurance refuses to pay, the responsibility for payment is on the patient/parent.**

*When we bill your insurance, it is at a contracted rate. **If you have a deductible, co-pay, or co-insurance, we are contracted with the insurance to bill you that amount.**

Private Pay

*Invoices are billed out the following month after speech therapy visits. Ex: visits for the month of November are billed out the first part of December.

*You are welcome to mail a check to Browning Speech Therapy. The address is on the invoice. You can call to pay with a credit, debit, or HSA card. The phone number is on the invoice as well. You can also leave a card on file for autopay.

Past Due Accounts

I agree to pay interest at the rate of 10% monthly on all past due balances over 90 days, from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee of up to 40% of the principal balance if my account is assigned to a collection agency.

Print name: _____

Signature: _____

Date: _____

Waiver of liability

BROWNING SPEECH THERAPY, LLC.

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I hereby release Browning Speech Therapy LLC, its employees, volunteers and owner from any and all liability, cost or expense associated with any injury sustained by any member of my family while participating in Browning Speech Therapy, LLC's programs. I give permission to Browning Speech Therapy, LLC to seek medical treatment in case of an emergency. I have read and understand Browning Speech Therapy, LLC's policies.

Print name: _____

Signature: _____

Date: _____

Communication Permission

Please read and sign the HIPAA form attached to this.
By signing below, you approve for Browning Speech Therapy, LLC, to communicate via text and email the patient's name, date of birth, diagnosis, contract information or scheduling with Browning Speech Therapy, LLC's Speech Language Pathologists and/or office staff in order to facilitate the best service and outcome for the patient.

Print name: _____

Signature: _____

Date: _____

Please email all signed pages to bethbrowning@me.com
If you want us to check coverage and bill your insurance, please include a copy of the front AND back of your insurance card.

AGREEMENT OF FINANCIAL RESPONSIBILITY- MEDICAID ONLY

BROWNING SPEECH THERAPY, LLC.

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Patient Name Last, First, Mi	Date of Birth (Mo/Day/Yr)	Medicaid ID #

Section 1

Description of non-covered service(s), for which the patient agrees to accept financial responsibility:

- Speech Therapy that exceeds (1) 30 minute session per week.
- No Show fees as stated in Browning Speech Therapy's Attendance Policy

Expected cost of non-covered service(s) $65.00 per half hour session

The provider of services, Browning Speech Therapy, LLC certifies that this office has an established policy for billing all patients, for services not covered by a third party. In accordance with state Medicaid provider billing guidelines, the patient has been advised prior to services being rendered the specific non-covered services(s) to be provided and the expected cost.

Completed by (print)_____ for the above provider.

Signature:_____Date_____

Section 2 (Patient or responsible party completes this section)

I am the patient or responsible party. I understand my health plan may not pay for the services described in Section 1. I have been told what the expected cost will be. I have been informed and have signed this agreement before receiving the described services. I have been told why I may be billed and agree to pay the bill as described in Section 1.

Signature of Patient or Responsible Party:_____Date_____

Responsible Party, if other than patient (print):_____

Relationship to Patient:_____

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bethbrowning@me.com 801-493-9690

Auto-Pay Authorization Form for speech therapy services provided by

Browning Speech Therapy

Schedule your payment to be automatically charged to your credit, debit or HSA card. Just complete and sign this form to get started!

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your credit, debit, or HSA card. You will be charged either the private pay rate if insurance isn't billed or the patient responsibility after the insurance has processed the claim. A receipt for each payment will be emailed to you. You agree that no prior-notification will be provided.

Please complete the information below:

I _____ authorize Browning Speech Therapy, LLC, to charge my
(full name)
card indicated below for the amount owed.

Patient's Name _____

Billing Address _____

City _____ State _____ Zip Code _____

Email _____ Phone _____

Credit Card Information

Card Number _____

Expiration Date _____

Security Code (CVV)_____

Zip Code _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Browning Speech Therapy, LLC, in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.