Contact: Frangelica Leo
158-01 Crossbay Blvd.
Howard Beach, NY 11414
347-593-TALK (8255)
Fax: 855-592-6874
TheLanguageLoungeNY@gmail.com

Welcome Parents and Caregivers,

We are so excited to have you join The Language Lounge Family. Thank you for choosing us to provide your therapy and language enhancement services. Our goal is to engage you & your child in an enriching and positive experience. We would like to take a moment to share our policies and procedures to ensure a happy and safe environment for all. Please sign and return all forms as promptly as possible. All forms must be returned prior to the commencement of therapy. You can feel free to email at the above email address, fax at the above phone number, mail to the above address or submit to your therapist at the beginning of the FIRST session. NOW AVAILABLE: YOU CAN FILL OUT ON OUR WEBSITE SECURELY AND SAFELY!

ALL NECESSARY PAPERWORK MUST BE SUBMITTED BEFORE THE START OF THERAPY:

- RSA's (If Applicable)
- IEP's (If Applicable)
- The Language Lounge Intake Form
- The Language Lounge Welcome Packet
- Signed Financial Policy
- Credit Card Authorization Form (if fee for service)
- Meal time questionnaire (if applicable)

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PATIENT INFORMATION

PLEASE PRINT FULL LEGAL NAMES FOR PATIENTS AND PARENTS

PATIENT: (first)_____ (middle)_____ (last)_____(sex) ____

Date of Birth: _____ Phone: (home)_____

Address: (street)_____

(city)_____(state)_____(zip)_____

Previous Therapy: _____Y _____ N Date of Last Eval: (SP) _____

Referred By: _____

PARENT/GUARDIAN NAME: (first)_____ (middle)_____ (last)_____

Date of Birth: _____SS#: _____

Address: (If Different)_____Cell Phone:_____

Employer: _____Occupation: _____Work Phone:_____

E-Mail: _____

OTHER PARENT NAME: (first)_____ (middle)_____ (last)_____

Date of Birth: _____SS#: _____

Address: (If Different)_____Cell Phone:_____

Employer: _____Occupation:_____Work Phone:_____

PRIMARY CARE PHYSICIAN:_____**PRACTICE GROUP NAME:**_____

Address:_____Zip _____Phone: _____Fax:_____

PRIMARY INSURANCE (IF APPLICAPLE):

Name, address, phone number of Insurance Company: _____

_____

Name of Insured: _____ Relationship to Patient:_____

Patient ID Number: _____ Group Number: _____

*Please have your insurance card ready so we may make a copy. Thank you.

SECONDARY INSURANCE:

Name, address, phone number of Insurance Company: _____

_____

Name of Insured: _____ Relationship to Patient: _____

Patient ID Number: _____ Group Number: _____

*Please have your insurance card ready so we may make a copy. Thank you.

AUTHORIZATION TO RELEASE INFORMATION/PAYMENT OF INSURANCE BENEFITS: *I hereby authorize The Language Lounge to furnish my insurance carrier any information acquired in the course of my evaluation or treatment necessary to complete my insurance forms.*

Signed:_____***(relationship to patient***_____ ***Date:*** _____

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PATIENT NOTIFICATION OF PRIVACY POLICIES

Purpose: to document the disclosure of policies regarding the storage, use and sharing of confidential information.

1. Confidential information is stored in a secure location.
2. Anyone who has access to any confidential information must sign a confidentiality agreement.
3. Employees have access only to information required to complete their job responsibilities.
4. Evaluations, therapy plans, progress reports and treatment notes are sent to Insurance companies, other pay sources, Department of Education districts, and referring physicians for the purposes of requesting doctor's orders, authorization for services, or to obtain reimbursement for services. Information may be sent via first class mail or fax or encrypted email with procedures in place to limit the likelihood of unauthorized access. This information will be sent one time and the date sent will be documented. In the event that the document has to be resent it will be dated as well.
5. Confidential Information is not shared with 3rd parties (with the exception of those listed above) without written approval from the patient or guardian. Therapists share information with each other and referral sources only as needed to provide the best services possible.
6. Giving photographs to the clinic is considered authorization for displaying the pictures in the waiting room.
7. The Office Manager serves as the Privacy Officer. If any client/guardian has concerns that confidentiality has been or is in danger of being breached, they are asked to report it to the Privacy Officer.
8. All attempts should be made to hold conversations, which may include confidential information in a location away from public access.
9. All computers containing confidential information are only accessed via a password. Employees only have access to information critical for their job responsibilities.
10. By requesting or initiating e-mail communications, patients/guardians agree to release The Language Lounge and its employees for any breach of confidentiality that may occur with information transmitted over the internet. The Language Lounge will not share information with 3rd parties or referral sources over the internet unless given approval.

I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES PRESENTED IN THIS DOCUMENT.

Patient/Guardian Signature _____ Date _____.

VIDEO TAPING/AUDIO RECORDING

On occasion, therapy sessions may be videotaped. These tapes are used by the therapists to improve their treatment skills and document progress. On occasion, these videos are used for training other therapists and identifying information is kept to a minimum. Please sign at the appropriate place below indicating your authorization for use of video taped sessions for training purposes.

I AUTHORIZE THE USE OF VIDEO TAPES/AUDIO RECORDING FOR THE PURPOSES OF TRAINING.
Patient/Guardian Signature _____ Date _____

I DO NOT AUTHORIZE THE USE OF VIDEO TAPES/AUDIO RECORDING FOR THE PURPOSES OF TRAINING.
Patient/Guardian Signature _____ Date _____

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FINANCIAL POLICY

PAYMENTS ARE EXPECTED THE FIfth OF EVERY MONTH FOR SERVICES THAT HAVE BEEN RENDERED THE MONTH PRIOR UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CHECKS, DEBIT CARD (with Visa or MasterCard logo), VISA, and MasterCard.

1. **INSURANCE:** Professional services are rendered and charged to you, not your insurance company. Please understand that the contract is between you and your insurance company and payment for services is your responsibility. Each company negotiates different benefits and clients are responsible for understanding their individual policies. For all insurance companies we will supply you with any paperwork needed for you to submit your claim. Special financial arrangements must be made with the Office Manager prior to starting treatment. Our office will not enter into a dispute with your insurance company over your claim. You are responsible to provide your insurance company with any additional information they may need from you.

2. **USUAL AND CUSTOMARY FEES:** Our fees are what are usual and customary in our area not what your insurance company feels are usual and customary. You are responsible for any fees that are above insurance company's usual and customary fees. We do not have a contract fee with ANY insurance company.

3. **SELF-PAY PATIENTS**: Payment is due on the fifth of every month for services that have been rendered the month prior (e.g. Payment is necessary on January 5th for all services provided to your child in the month of December). An invoice will be sent to you before the fifth of the month and a check can be mailed to The Language Lounge. You also have the option of auto-charging your visits. We will obtain your credit card information from you and charge your credit card on the fifth of the month for all services rendered the month prior. Lastly, you have the option of paying in installments on a per visit fee schedule. See attached Credit Card Billing Authorization form. **Please note every client that is private pay MUST fill out the Credit Card Billing Authorization Form.** It will only be used in the event that payment is not collected in a timely manner (you have a maximum grace period of 10 days and/or 15th of the month) **PLUS a $25.00 late fee if NOT received.** In addition: your credit card will be charged if:

    - Proper cancellation procedures are not followed as noted in the Welcome Packet (*$25.00 per 30 minute session, $35.00 per 45 minute session, and $50.00 per 60 minute session canceled)*
    - If for any reason services are terminated you will be charged for any outstanding balance for services rendered if arrangements haven't been made.
    - A check is returned for insufficient funds ($25 fee)

4. **AUTOCHARGE:** It is requested that a credit card be kept on file for any clients treated. See the attached Credit Card Billing Authorization form for details.

5. **NON-PAYMENT:** If payment is not made by the grace period of the 15th of each month, and the credit card was denied we must discontinue services. The account must be paid in full before therapy can be resumed.

    - ***BROKEN APPOINTMENT POLICY:*** *Please consider your scheduled appointments carefully.* ***We require a 24-hour cancellation notice or a fee will be charged.*** $25.00 per 30 minute session, $35.00 per 45 minute session, and $50.00 per 60 minute session canceled (Please understand that canceling late or having a therapist show up at your door and your child is napping, and/or you are not home is inconsiderate. Your therapist has allotted time for your child and can give time to another student who has adhered to the policy). We understand if certain special circumstances occur, please inform the director and consideration will be given on a case by case basis.
    - If you repeatedly miss your scheduled appointments therapy may be terminated at our discretion. Please cancel your session as soon as possible if your child is ill. Children should not attend therapy if they have had a fever in the past 24 hours or have diarrhea.

6. **CONFIDENTIALITY:** In an effort to ensure confidentiality we are unable to speak with anyone other than the patient or responsible party regarding an account without written approval from the patient. **Minor Children**: Accounts for minor children of separated or divorced parents are the responsibility of the parent who consented to the therapy. The Language Lounge will not be involved with custody matters.

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7. **OFFICE FEES:** If you present a check for insufficient funds, or place a stop payment on an issued check, you will be charged a $25.00 fee for processing. Insufficient funds checks will not be reprocessed. You must pay by cash or money order.

I HAVE READ, UNDERSTAND AND AGREE TO THE STATEMENT OUTLINED ABOVE.

Signed (Responsible Party) _____ ***Date:*** _____

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POLICIES FOR YOUR RECORDS

1. OBSERVATIONS

a. Parent observation- The Language Lounge strongly recommends that parents be active participants in therapy so that you can continue techniques demonstrated throughout your child's day.

b. Student Observations- The Language Lounge assists in the training of new Speech/Language Pathologists. We often have students observe therapy sessions to learn more about what we do. These students sign confidentiality agreements and will not disturb the therapy sessions. In addition, we occasionally accept student interns who will provide additional free therapy sessions under direct supervision. If you have strong objections to student observations, please let us know as soon as possible. We will discuss the use of interns with you privately prior to having them participate in your therapy.

2. MISSED SESSIONS

a. **HOLIDAYS**- We follow the DOE calendar. No therapy will provided when schools are closed. All sessions scheduled for these days will be cancelled and not made-up.

b. **CLIENT CANCELLATIONS**- All cancellations require at least a 24-hour notice. All cancellations without a 24-hour notice may be subject to a Missed appointment fee (see financial policy for details).

c. **ATTENDANCE POLICY**- **To ensure that our services are effective and efficient, your child is required to attend at least 70% of all scheduled therapy sessions, (including make up sessions) in an 8 week consecutive period.** Cancellations by the therapist will not be included in this percentage. Should you fall below the required 70% attendance rate we may discontinue further services for your child.

d. **THERAPIST CANCELLATIONS**- Your therapist will notify you at least 1 week in advance for all planned cancellations and as soon as possible for emergency cancellations. Cancelled sessions will be rescheduled whenever possible depending on the availability of your therapist.

e. **OTHER CANCELLATIONS**- Sessions may also need to be cancelled in order for therapists to attend IEP meetings or other types of team meetings. We feel it is vital to provide a continuity of care across all service providers and attendance of these meetings helps us assure that your child will be provided the services to which they are entitled. You will be given plenty of notice if sessions must be cancelled and every attempt will be made to reschedule.

3. Children with RSA's and IEP's

a. Makeups will be given according to your child's therapy mandate (e.g. If your child has a mandate of twice per week and he/she is absent for one of those sessions the makeup must be completed that same week. If it is made up the week after then your child would be seen three times, which exceeds his/her mandate, which is not allowed!)
b. Makeup sessions will be billed as they are completed

4. QUESTIONS AND CONCERNS

If you have any difficulties with your therapist regarding scheduling, treatment techniques being used or anything else that relates directly to the therapeutic process, please express your concerns directly to the therapist. If you are unhappy with the outcome or your discussion, please call Frangelica Leo at the office to discuss your concerns. We are always willing to assist in any way possible.

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This is a reference form for your use only

We know that when your child needs help, financial issues may be the least of your concerns. However, it's important to carefully consider the financial liability for your family when planning for therapy. This form is being provided for your benefit to assist you in determining the extent of your insurance coverage for speech and language services. Private therapy can be very expensive and the information gathered may help you determine how much therapy your family can reasonably afford.

We recommend that you ask specific questions when contacting your insurance company and keep careful records of all conversations including names of people you have spoken to, the information given to you and the dates you made contact. Please be advised that regardless of information given over the phone, most insurance companies will not guarantee payment. Historically, most insurance companies will only cover speech/language therapy if there is a medical condition present and the therapy is restorative in nature. Your speech/language pathologist and physician should be consulted to determine if a medical condition is present.

Please do not hesitate to contact our The Director if further information is needed. Once you have answered all of the following questions please forward a copy of the completed form to our office.

Name of Contact: _____ Date Called: _____

Questions to Ask:

1. Does my policy allow services to be provided by an "Out of Network" provider and how much will I be responsible for?
2. Are there any limitations regarding age of the patient or the types of disorders covered?
3. What is the maximum number of therapy sessions allowed per calendar year?
4. If my child requires more than the maximum number of visits allowed per year, what is the procedure to get further visits approved and paid?
5. What is the deductible amount that I must pay before my insurance will begin reimbursing me?
6. Is this deductible amount based on the actual cost of therapy or the percentage the insurance company will pay?
7. Is it necessary to obtain prior approval for speech and/ occupational therapy? If so, what specific paperwork is required?
8. Is it necessary to obtain a "letter of medical necessity: from my primary care provider and/or speech/language pathologists?
9. Will my speech/language pathologist be required to send progress reports and treatment plans? If so how often will these need to be sent?
10. How long can I expect to wait for reimbursement after I submit an invoice?

Frequent CPT codes: 92507 for individual speech therapy provided