**The Speech and Learning Center, L.L.P.**

**New Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M or F

Who does the patient live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent #1 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent #2 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adult Patient:

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our clinic? (Please circle all that apply)

 Friend Physician Sienna Newsletter Insurance Sugar Land Magazine Sign Internet Search Employee School/ECI Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list specific friend or physician so we can thank them for the referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Insured’s address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Speech and Learning Center, L.L.P.**

**Emergency Medical Release**

Dear Patient:

In the event that medical attention is required while on the premises of The Speech and Learning Center, L.L.P., it will be necessary to have authorization for medical care and an emergency contact on file. Please fill out the following information in its entirety.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Health/Medical Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Numbers (Provide 2 numbers): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caretaker Phone Numbers if different from above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Name/Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give my permission for The Speech and Learning Center, L.L.P., to provide emergency medical services for minor injuries received while on the premises. In the event that an emergency is life threatening, I give my permission for The Speech and Learning Center, L.L.P., to contact emergency medical personnel.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Speech and Learning Center Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Speech and Learning Center, L.L.P.**

**Release/Request of Information**

**1. Permission to fax evaluation report to physician**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (responsible party’s name) give my permission to The Speech and Learning Center to release \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name) evaluation reports and patient records to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (physician’s name(s)).

By signing below, I acknowledge the above statement will remain valid until I provide a written request to discontinue permission.

Responsible party’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Permission to correspond with caregiver via email**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (responsible party’s name) give my permission to The Speech and Learning Center to send/receive information regarding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name) therapy via email to patient or patient’s caregiver.

By signing below, I acknowledge the above statement will remain valid until I provide a written request to discontinue permission.

Responsible party’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Permission to correspond with other professionals**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (responsible party’s name) give my permission to The Speech and Learning Center to release/receive information regarding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name) to professionals involved in this patient’s care. Such professionals may include physicians, teachers, speech pathologists, occupational therapists, physical therapists, reading specialists, private tutors, etc. Correspondence may occur via email, telephone, mail, or fax.

By signing below, I acknowledge the above statement will remain valid until I provide a written request to discontinue permission.

Responsible party’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Permission to correspond with relatives**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (responsible party’s name) give my permission to The Speech and Learning Center to release/receive information regarding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name) to my child’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of relative).

By signing below, I acknowledge the above statement will remain valid until I provide a written request to discontinue permission.

Responsible party’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Speech and Learning Center, L.L.P.**

**Office Policy**

We appreciate the confidence you have expressed in selecting us as your speech therapy and occupational therapy provider. If you have any questions about our services, fees, or other aspects of your care, please feel free to discuss them with us.

**Fee Agreement**

\_\_\_\_ Payments for assessment and therapy are due prior to rendering of services unless prior arrangements have been made with your insurance carrier. Our office accepts **cash or checks only**. Payment in full for services rendered is required at the time of service for:

1. Patients without insurance
2. Patients who do not provide us with contracted insurance information
3. Patients whose insurance plans do not cover speech therapy
4. Patients who are required to have prior referral/authorization from their insurance carrier or Primary Care Physician, who have not obtained such authorization.

\_\_\_\_ All amounts owed by patients under contracted insurance plans (copays, coinsurance, deductibles, and non-covered services) are payable at the time of service. Any service that is rendered by this office which is not a covered benefit under your insurance policy is your responsibility to pay. In the event that your payment is not made in a timely manner, information regarding your delinquent account will be forwarded to our attorney or collection agency. Should this become necessary, the customer agrees to pay reasonable attorney and/or court fees and any other costs incurred by The Speech and Learning Center, L.L.P.

\_\_\_\_ Our staff will assist you in dealing with your insurance company by verifying your benefits using the member services phone number given on your insurance card; however, this verification is not a guarantee of payment and it is your responsibility to know and understand your own insurance benefits, coverage, pre-existing condition clauses, and referral/authorization requirements. Please remember that your insurance is a contract between you and your insurance company and/or employer. We recommend that any questions regarding the amount of insurance coverage be discussed directly with your insurance company and/or employer. It is your responsibility to notify us of changes in insurance. If changes in insurance result in non-payment, the patient is responsible for payment.

\_\_\_\_ Additionally, if payment from your insurance company is not received within 45 days of the billing date, the amount owed will be your responsibility. If, in the future, insurance payment is received you will receive a refund or credit.

**Return Check Fees and Late Charges**

\_\_\_\_ The Speech and Learning Center charges a **$35.00 returned check fee** on each check not covered by your bank. A **$10.00 finance charge** will be added per month to invoice payments not received by the due date.

**Appointments & Scheduling**

\_\_\_\_ Due to the rising number of patients who do not cancel their appointments when circumstances prohibit them from appearing at our office, we have instituted a “no show/late cancellation fee.” The Speech and Learning Center, L.L.P., requires a 24-hour cancellation notice. **Appointments broken without 24-hour notice will be charged $35.00.**  You may choose to reschedule your session at another time within 2 weeks to avoid these charges. This fee will not be charged if a telephone cancellation due to illness or extenuating circumstances is received in our office **prior** to your appointment time. This fee is **not** billable to your insurance company.

\_\_\_\_ Three consecutive no shows result in automatic removal from the schedule.

\_\_\_\_ Please do not use email as a form of cancelling appointments as we are not always able to check emails.

\_\_\_\_ Please do not leave your children unattended in the lobby. Our office cannot be responsible for children left unattended.

I authorize The Speech and Learning Center, L.L.P. to provide appropriate evaluation and treatment as needed. Additionally, I authorize the release of any necessary information acquired in the course of the evaluation or treatment process to my referring physician, health plan/ insurance representative, or attorney. I have read and understand the above information as well as the insurance benefits verified from my insurance carrier, if applicable. I understand that I am responsible for all charges whether or not reimbursed by my insurance company.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Print Name Date

**WRITTEN ACKNOWLEDGMENT OF RECEIPT OF**

**THE SPEECH AND LEARNING CENTER, L.L.P**

**NOTICE OF PRIVACY PRACTICES**

By signing below, you acknowledge receiving The Speech and Learning Center, L.L.P. Notice of Privacy Practices (“Notice”). The Notice explains how The Speech and Learning Center, L.L.P. may use or disclose your protected health information for treatment, payment, and health care operations purposes. “Protected Health Information” means your personal health information found in your medical and billing records.

The Speech and Learning Center, L.L.P. reserves the right to change the Notice from time to time. A copy of the current Notice or summary of the Notice will be posted. The effective date of the Notice will appear on the first page of the Notice or summary. The Speech and Learning Center, L.L.P. will have available for you, at your request, a copy the current Notice in effect.

***Your signature below only acknowledges that you have RECEIVED the Notice.***

If you have any questions about the Notice, please contact The Speech and Learning Center, L.L.P.

Name of Patient (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient’s Representative (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of Patient’s Representative to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Patient’s Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

We care about our patients’ privacy and strive to protect the confidentiality of your medical information at this facility. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this facility is required by law to maintain the privacy of that information.

This facility is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer(s) at this facility.

**Who Will Follow This Notice**

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this facility who may need access to your information must abide by this Notice.

**Changes to This Notice**

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date on the posted copy.

**THE SPEECH AND LEARNING CENTER, L.L.P.**

**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**.

EFFECTIVE DATE: January 1, 2005

**How We May Use and Disclose Medical Information about You**

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

**For Treatment**: We may use medical information about you to provide you with medical treatment or services. Example: If your assigned Speech Pathologist is on vacation, he or she may disclose to another therapist about you or your child.

**For Payment**: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you or an insurance company. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

**For Health Care Operations**: We may use or disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

**Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization**

* As required during an investigation by law enforcement agencies
* To avert a serious threat to public health or safety
* As required by military command authorities for their medical records
* To workers’ compensation or similar programs for processing of claims
* In response to a legal proceeding
* Other healthcare providers’ treatment activities
* Other covered entities’ and providers’ payment activities
* Other covered entities’ healthcare operations activities (to the extent permitted under HIPAA)
* Uses and disclosures required by law

We may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

**Uses and Disclosures of Protected Health Information Requiring Your Written Authorization**

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke that authorization, we will therefore no longer use or disclose medical information about for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care we have provided you.

**YOUR INDIVIDUAL RIGHTS REGARDING**

**Disclosures and Changes to Your Medical Information**

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. To request restrictions, you must submit your request in writing to the Privacy Officer(s) at the facility. In your request, you must tell us what information you want to limit.

**Right to an Accounting of Non-Standard Disclosures:** You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officers at this facility. Your request must state the time period for which you want to receive a list of disclosures that is no longer that six years, and may not include dates before January 1, 2005. Your request should include in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

**Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer(s) at this facility. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**YOUR ACCESS TO MEDICAL INFORMATION**

**Right to Inspect and Copy**: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records. Information complied for use in a civil, criminal, or administrative action or processing, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer(s) at this facility. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of our current Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer(s) at this facility.

**Right to Request Confidential Communications:** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you make your request to the Privacy Officer(s) at this facility. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on this facility.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer(s) at this facility or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.