



1 Bethany Road Suite 60, Bldg 5
Hazlet NJ 07730

Phone (732) 888-3912
Fax (732) 888-3916
speechstartnj.com

120 East River Road, Suite 3
Rumson, NJ 07760

Privacy Policy

We, here at Speech Start, LLC are vigilant to protect patient confidentiality. No information regarding our patients is shared or distributed with any other person or organization without the signed authorization of the patient's parent or guardian.

Any questions or comments may be directed to our Privacy Compliance Officer, Bernadette Mullen.

If you have any comments, complaints, etc., please call (732) 888-3912.

Please sign and date.

I _____ have read the above privacy policy. Date: _____

Evaluations must be paid for in full on first day of testing. Please allow therapists up to 4 weeks to complete report write-up.

Speech Start, LLC

Date: _____

Case History

Name: _____ Age: _____

Address: _____
Street City Zip Code

Telephone: _____ Birth Date: _____

Email Address: _____

Father/Guardian Name: _____ Occupation: _____

Employer: _____ Address: _____

Business Telephone: _____ Cell Phone: _____

Mother/Guardian Name: _____ Occupation: _____

Employer: _____ Address: _____

Business Telephone: _____ Cell Phone: _____

Siblings - Age

Hearing Screened @ 25dbHL A.N.S.I.: Passed _____ Failed _____

Medical History/ Neurological Diagnosis:

Allergies: _____

Earaches: Right: ___ Left: ___ Otis Media: Right: ___ Left: ___

Vertigo: _____

Tonsillectomy: _____ Adenoidectomy: _____

Please list any other surgeries and dates: _____

Medications: _____

Recurrent Illnesses: _____

Please list any other significant information: _____

Case History

Client Name: _____

Pediatrician: _____

Phone: _____ Address: _____

Pre-Natal:

Delivery:

Post-Partum

Length/Term: _____ Duration/Labor: _____ Birth Weight _____

Illness: _____ Position: _____ Anoxia: _____

Medications: _____ Anesthesia: _____ Transfusions: _____

Complications: _____ Hospital Stay: _____

Rh Factor: _____

Other: _____

Social History: (Please list age at which child has achieved the following)

Sitting: _____ Responds to sound: _____ Feeds Self: _____

Standing: _____ Babbling: _____ Drinks from glass: _____

Walking: _____ First Word: _____ Eats with Spoon: _____

Crawling: _____ Sentences: _____ Toilet training: _____

Balance: _____ Speech Development: _____ Temper Tantrums: _____

Dominance: _____ Dresses Self: _____

Rides a Bicycle: _____ Gets along with others: _____

Language Spoken at home: _____

Education:

Nursery School: _____ Teacher: _____

Address: _____

Elementary School: _____

Junior High School: _____

Individual tutoring – Subject: _____

Reason for Evaluation/Initial concern

Referred by: _____

Parent Signature

Date

Financial Agreement
(Mandatory for all clients)

Speech Start, LLC requires payment for all services provided at time of service, NO EXCEPTIONS. At no time will any service be delivered without receipt of payment. A receipt will be issued for all paid-in-full services. Reduplication of receipts and or reports can be supplied at a fee of \$25.00 per request payable in advance. Checks made out to Speech Start, LLC, cash, and credit/debit cards are accepted. A **10% late fee** will be charged monthly and added to your bill 30 days overdue and service will be terminated.

Termination of service is considered valid with a two week written notice to Speech Start. Any service discontinued without the two week written notice is billed at the full rate and subject to a **10% late fee**.

I, _____, understand that any services rendered to
Name of Parent/Guardian
_____ is my responsibility, and I agree to pay for these
Name of Child
services in full prior to service delivery, regardless of my child's attendance.

If you have any questions regarding payment, please see front desk.

Insurance Financial Agreement
(MANDATORY if using insurance)

Speech Start, LLC requires copayment for all services provided at time of service. At no time will any service be delivered without receipt of copayment. A receipt will be issued for all paid-in-full services. Checks made out to Speech Start, LLC, cash, or credit/debit cards are accepted. A **10% late fee** will be charged monthly and added to your bill 30 days overdue and service will be terminated. Any services not covered by insurance are the responsibility of the client and must be paid in full upon receiving Explanation of Benefits.

Rates

.5 unit therapy: \$70

.75 unit therapy: \$105

1.0 unit therapy: \$150

Evaluation: \$400

I, _____, understand that any services rendered to
Name of Parent/Guardian
_____ is my responsibility, and I agree to pay the

copayment for services in full prior to service delivery.

Insurance Plan Information

A copy of the front and back of the insurance card and policy holder license is required at the time of service.

Insurance Carrier: _____

Plan Type: _____

Policy Holder (Name-First and Last): _____

Policy Holder Address: _____

Policy Holder DOB: _____

Client (Name-First and Last): _____

Client Address: _____

Client DOB: _____

ID #: _____

Group #: _____

Policy #: _____

Policy Holder License #: _____

Credit Card Information

(MANDATORY for all clients)

Speech Start, LLC requires that all clients place a credit card on file. The credit card will not be charged without the card holder's permission and information will be kept private. Credit cards will be charged if the client incurs debt that is not paid within 30 days of the date of service. Clients can pay by check or cash if they prefer but a card is required to be kept on file.

Card Type: _____

Name on card: _____

Card Number: _____

Exp. Date: _____

CVC# (On back of card): _____

Billing Zip Code:

Information Release (Optional)

Speech Start, LLC is occasionally requested to submit information for clients to insurance companies, school districts, physicians, or other therapists. We cannot do so unless we have your written consent. We also may ask for and obtain information from outside sources regarding your child in order to provide quality service.

I authorize Speech Start, LLC to release information and/or acquire information about my child, _____, during the course of evaluation or treatment for medical, professional, or insurance purposes. Photocopy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian Signature

Date

Print (Parent/Guardian name)

Photo/Video/Audio Release for Intervention (Optional)

I, _____, hereby authorize Speech Start, LLC to take or acquire photo, video, or audiotapes of my child, _____, during evaluation and/or treatment for intervention purposes only. The photo, video, or audiotapes will not be released to outside parties without permission from the parent(s)/guardian(s).

I, _____, hereby release Speech Start, LLC from liability for any claims by me or any third party in connection with my participation.

Parent/Guardian Signature

Date

Photo/Video/Audio Release for Publishing (Optional)

I, _____, hereby authorize Speech Start, LLC to take or acquire photo, video, or audiotapes of my child, _____, during therapy for use on print, online, and video-based marketing materials, as well as other company publications.

I, _____, hereby release and hold harmless Speech Start, LLC from any reasonable expectation of privacy or confidentiality associated with the images above. I also acknowledge that my participation is voluntary and I will not receive compensation for photo, video, or audiotapes taken of my child.

I, _____, hereby release Speech Start, LLC, its contractors, its employees, and any third parties involved in the creation of publication of marketing materials, from liability for any claims by me or any third part in connection with my participation.

Parent/Guardian Signature

Date

Current Out of Pocket Rates

<i>Type of Service</i>	<i>90 Minute</i>	<i>60 Minute</i>	<i>45 Minute</i>	<i>30 Minute</i>
Feeding Therapy, Individual	N/A	\$115	\$87	\$58
Speech Language Therapy, Individual	N/A	\$115	\$87	\$58
Speech/Language Therapy, Group	\$65	\$50	N/A	N/A
Literacy Instruction, Individual	N/A	\$70	\$52.50	\$35
Literacy Instruction, Group	N/A	\$60	\$45	\$30
Parent Meeting/ Instruction/Phone Conference	N/A	\$70	N/A	N/A
IEP Meeting	N/A	\$115	N/A	N/A
Speech/Language Evaluation	N/A	\$377.00 for full evaluation, regardless of length or number of sessions	N/A	N/A

Cancellation Policy

All Speech Start Clients,

We wanted to take this opportunity to update you on an upcoming business policy change. As of **12/1/2018**, please be advised that Speech Start will require at least 24 hours notice for all cancellations. Any cancellation with less than 24 hours notice will be subject to a cancellation fee of \$30. If a client does not show to the time of the appointment without giving notice or calls to cancel minutes before their session, they will be charged the full rate of the session (Please see Service Rates document). If a client cancels less than 24 hours more than three times, they too will pay the full rate for the session.

We thank you in advance for your cooperation with this policy change. We are striving to bring you better service and we hope we can continue to partner in assisting your children to reach their full potential!

Discontinuation of Services Policy

All clients must give at least 2 weeks' written notice when discontinuing services. All sessions within that time period must be attended in order to receive a discontinuation of services report.

I, _____, understand that any fees rendered to
Name of Parent/Guardian
_____ is my responsibility, and I agree to pay for these
Name of Child
services in full prior to service delivery, regardless of my child's attendance.

If you have any questions regarding payment, please see front desk.

Thank you,

Speech Start Staff