82 Bethany Road, Suite 1
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 the first day of testing. Please allow therapists up to 4 weeks (or 30 days) from completion of testing date to complete report write up.

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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: _____

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Medications: _____

Recurrent Illnesses: _____

Please list any other significant information: _____

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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

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Referred by: _____

_____ _____

Parent Signature Date

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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.

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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 #: _____

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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)

Please note, video surveillance will be recording all sessions

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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

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Current Out of Pocket Rates

Type of Service	*90 Minute*	*60 Minute*	*45 Minute*	*30 Minute*
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

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Cancellation Policy

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.

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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.

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.
