Dynamic Therapy Associates, Inc.
Speech Language Pathology and Assistive Technology Specialists
3105 Creekside Village Drive, Suite 603/604
Kennesaw, GA 30144
Phone 770-974-2424 Fax 866-384-6451

Client Information Form

Name of Client:	
Date of Birth:	
☐ Male ☐ Female	
Medical Diagnosis:	
Speech Diagnosis:	
Parent/Guardian Names:	
Home Address:	
Primary Contact Name:	Phone Number: Email Address:
Permission to Text this Number: ☐ Yes ☐ No	
Additional Contact Name:	Phone Number: Email Address:
Permission to Text this Number: ☐ Yes ☐ No	
Preferred Contact Party/Method: ☐ phone ☐ alternate phone ☐ email ☐ text	

Dynamic Therapy Associates, Inc.

Academic Environment/Work Environment/Therapies:
School Attending/Place of Employment:
Teacher/Parapros (if applicable):
Other Therapies:
Frequency of Other Speech Therapies/Month

Please note, Medicaid will only allow 8 units of speech therapy services per month, per patient. This includes feeding therapy, speech/language therapy and augmentative communication therapy and evaluation. Our therapists can provide all of these services or share units with other professionals.

Insurance, Medicaid/Medicare Information: Copy of card must be provided prior to service
Medicaid Number:
Insurance Co. Name:
Insured's Name:
Insured's Date of Birth:
Insured's Social Security Number:
Employer Name & Phone #:

Physician Information
Doctor Name:
Phone Number:
Office Name/Address:
Fax Number:

We will need a prescription from your primary care physician prior to service to provide therapy funded by your medical insurance. You may use the downloadable prescription form to assist your physician in prescribing services we provide.

Patient Name: **Date:**

Dynamic Therapy Associates, Inc.

July 12, 2018

Release of Benefits & Financial Obligations

This practice provides services according to the fee schedule enclosed in this packet. Medicaid and insurance will be filed upon request although discounts will not be given for filed claims.

Adult clients (over 21 yrs) who have Medicaid and Medicare clients must be billed through another agency. Please let this office know well in advance if this is your funding. We are able to serve adult patients through medical insurance, private payment, self-directed Medicaid waivers or through negotiated contract.

Please initial the appropriate statements(s)

_____Patient is being seen through his/her **Medicaid/Medicare** plan.

_____Patient is **not** being seen through **Medicaid/Medicare.** I understand that I am responsible for all speech therapy bills which must be paid within 30 days following services or will be subject to a fee of 1% of the total bill added daily every day after 30 days from the date of service.

____I agree for all **insurance and Medicaid** payments to be made directly to this office. Such payments will be applied to the client's bill for services. All clients except Medicaid participants will be expected to pay the remainder of the bill as outlined above. You will be responsible for your co-pay on the day of service for each visit.

Cancelled therapy sessions are a problem for this office, as Medicaid does NOT make payment for missed appointments. If appointments are cancelled 24 hours in advance it is possible for the therapist to reschedule clients to make up for missed sessions. Please give 24-hour notice *when possible* when you know your child will be absent. If the therapist needs to cancel therapy, she will give you the same consideration. I understand some events are impossible to predict and therefore expect that you will not always be able to comply with this request although I *highly* appreciate your efforts in this regard. Weekly standing appointments will be cancelled for any client missing greater than 5 appointments without prior notice.

_____I understand and accept the terms of therapy as outlined above.
Parent/guardian/client signature & date

Patient Name: **Date:**

Dynamic Therapy Associates, Inc.

PERMISSION for RELEASE OF INFORMATION

I, _____ give permission for approved staff of Dynamic Therapy Associates, Inc. to engage in the following activities regarding information/documents pertaining to myself/my child:
_____

- Review any pertinent evaluations, notes or treatment plans
- Discuss treatment and assessment objectives, outcomes or methods
- Consult with pertinent professionals regarding the above either in person, on the phone, through e-mail or fax

This permission is extended for contact with the following parties: (please note specific parties or note "**all as needed**" on the lines below)

_____

I have been provided with the Notice Of Privacy Practices and agree with the current procedures in place to ensure the protection of my (or my child's) confidential health information.

Signed: _____ Date: _____
parent, guardian, patient

Witnessed by: _____

Patient Name: **Date:**

Dynamic Therapy Associates, Inc.

VIDEO/Movie File/Photograph RELEASE FORM

I give my permission for _____to be included in videotaping or photographing of therapy, school or community activities. I understand that all videotaping/photography will be related to therapy, and/or community/school involvement.

Full names will not be used in professional trainings although pertinent characteristics of your/your child's communication and development may be discussed for the purpose of educating professionals and families regarding best practices in teaching persons with communication challenges. **Full names will not be used** and the utmost respect will be used in every discussion. We deeply appreciate your willingness to be a part of our education of other professionals and families to better the lives of all people with communication challenges.

I acknowledge that I am giving my verbal and/or written permission for all previous and future video/photographs made of myself or my child by Dynamic Therapy Associates, DTA Schools and/or Vicki K. Clarke and will allow the use of these videos/movie files and photographs to be used in future professional presentations, online and print publications. I agree that these images may be used for educational, promotional and advertising purposes on videotape, audiotape, film, photograph, television, radio, digital, internet (including social media). I understand the images may appear in publications, promotions, broadcasts, advertisements, and posters.

I acknowledge that I have read this Videotape/Photography Authorization document and agree to its terms. I release Dynamic Therapy Associates, Inc and its agents from liability for any violation of any personal or proprietary right I may have in connection with such images. I understand I will receive no compensation, monetary or otherwise, regardless of whether or not any image is published.

Individual/Parent or Guardian:

NAME_____

SIGNATURE_____

DATE_____

Patient Name: **Date:**

Dynamic Therapy Associates, Inc.

Therapy Service Delivery Agreement

Practice Policy Regarding Emergency Procedures, Health Maintenance and Behavior Management for Patients

PLEASE READ CAREFULLY

Thank you so much for choosing Dynamic Therapy Associates to provide care for you or your family member. We take our obligations to you very seriously and strive to provide progressive therapy services to patients without exception. In order to provide a healthy, positive, safe and productive service for all patients, we have several policies designed to allow us to care for your family.

A responsible party must remain on site at all times for all underage patients or adults under guardianship.

Our staff is unable to take responsibility for making decisions or carrying out supports for health, medical, hygiene or behavioral needs without a responsible party present. If we experience any emergency situation without a family member in attendance, we will call 911 immediately.

Behavior Management

The staff at Dynamic Therapy has extensive experience in providing positive therapy environments for our patients. We regularly provide visual and behavioral supports for patients needing a highly structured and predictable environment. Our patients have different levels of need for behavior management and we are comfortable providing this support as necessary.

We are not, however, formally trained behavior intervention specialists. We do not develop behavior plans for individuals as you would receive from a behavioral psychologist. We will gladly incorporate behavioral protocols provided by your behavioral psychologist into your child's therapy session after review and agreement from all parties. It is critical for the safety of your child, our other patients and staff that all behavioral concerns be discussed prior to the initial therapy session or when behaviors become an issue during the course of services. We will not refuse service to a patient simply because a behavioral concern exists, but it is imperative that we understand the nature of the concerns prior to therapy implementation. Without a clear understanding of the patient's needs, *therapy will be ineffective*. It is important that patients are in a teachable mode when they attend therapy. We will do everything within our power to ensure that this is the case.

We have the following policies regarding behavioral concerns:

1. **Patients who are in the midst of a behavioral crisis (severe anxiety, aggressive or self-injurious behaviors) are never to be brought into this office.** Patients entering the office in an unresolvable behavioral crisis will be dismissed for the day so that they can be cared for appropriately. This policy is designed to protect both your child and the other, sometimes medically fragile, children who attend therapy in our office. We do not have the training or supports necessary to assist in these situations. *Your attendance record will not be impacted if you need to cancel due to an infrequent behavioral crisis.*

Patient Name: **Date:**

2. **During the course of therapy, the first time a patient becomes aggressive toward others or self-injurious, the therapy session will be discontinued immediately.** The family should assist the child in leaving the clinic at this time and a follow up consultation will be scheduled to allow for discussion and intervention planning with the family. If behaviors are not resolved by our intervention techniques within three to five sessions, we will refer you to a behavioral psychologist and/or psychiatrist for a more comprehensive analysis of the situation. Patients with unresolved anxiety, aggressive or self-injurious behaviors will not return to therapy until a formal behavior plan is developed by a behavioral specialist. Return to therapy may involve a decrease in service time and gradual build back to former service levels to implement functional communication and behavioral intervention plans. *Current patients who have established behavioral plans, developed by either the DTA therapy team or a behavioral psychologist, will maintain their current level of service delivery with agreement from the therapist and at the discretion of our administration.*

Medically Fragile Patients and Those With Significant Health Concerns

Patients who have a medical condition which may require an emergency medical response should inform their therapist and this office prior to attendance at therapy. We should be made aware of patients who have recurring seizures. If a patient has a seizure response plan, this should be shared with our administration and your individual therapist.

General Infection Control Procedures

We have up to 150 patients in our office each week. In an effort to decrease the transmission of viruses and infections we allow 5-10 minutes at the end of each session to wipe down surfaces and clean our hands using antibacterial cleansers and surface cleaning supplies.

We will make an effort to decrease risks for everyone in the clinic by cancelling sessions for therapists who have an active, contagious condition. Although we make every effort to have consistent weekly therapy services, we recommend families cancel sessions when patients are contagious. We will offer to make up any missed sessions over the course of the month.

If your child is immune compromised for any reason, please inform the administration and your individual therapist prior to initiating therapy services. We will make every accommodation possible to provide a safe, healthy environment for all patients.

Please do not bring a patient into the office with an active transmittable medical condition, for example, within the past 24 hours a fever over 100 degrees, stomach/flu virus, active or unmanageable ear/nose/throat discharge. Your attendance record will not be impacted by absence due to this type of infrequent illness, with as much notice as possible.

Patient Name: **Date:**

Dynamic Therapy Associates, Inc.

Attendance for Weekly Scheduled Therapy (please initial blanks)

After our initial evaluation we have recommended a level of service we believe will provide the best outcome for your child. Once this service delivery has been agreed upon, it is important that patients attend regularly as scheduled. Inconsistent services will result in a less than optimal outcome, so therapy will not continue for patients who cannot consistently attend their sessions as agreed upon.

_____**Patients should miss no more than one session a month to guarantee the best possible outcomes.**

If you have difficulty in attending regularly, please inform your therapist and our administration so that we can develop a service delivery plan with you with realistic goals for your family. We can offer you a schedule of treatment that could include weekly, biweekly or monthly visits to meet your family needs.

Please give us 24 hour notice as possible if you will not be attending therapy. We will also attempt to give you the same consideration. We understand that **unexpected illness or behavioral crisis** is not predictable, and you and our staff may need to cancel, on occasion, on the day of service. We have a waiting list at all times, so we need to be fair to the other families waiting for our help.

_____**Therapy services will be discontinued for any patient missing 3 sessions without prior notice (i.e. "no shows")**

If you need to miss more than 4 consecutive sessions, even with notice, we cannot guarantee we can reserve your appointment day/time. If your appointment time has to be reassigned, we will attempt to get you rescheduled as conveniently as possible upon your return to regular appointments. We will make every effort to accommodate unique situations requiring your absence as much as possible.

Speech Therapy services are provided on a **per visit basis**. Individual services are **not billed based on time**. Individual services typically vary from 20-30 minutes based on your child's needs, state of readiness to learn and insurance coverage. Some services can be accomplished back-to-back during one office visit resulting in an average 45-60 minute visit. A responsible party must be available during the entire session in the event that a patient becomes unable to complete a session.

I have read and understand the above therapy policies and practices of Dynamic Therapy Associates, Inc. regarding the services provided for my child. I agree to the above terms and request services continue for my child,

_____
Patient

_____ _____
Parent/guardian *Date*

Patient Name: **Date:**

Dynamic Therapy Associates, Inc.

NOTICE OF PRIVACY PRACTICES
EFFECTIVE DATE: MARCH 1, 2003
Revised April 10, 2014
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Vicki Clarke, 3105 Creekside Village Dr., Suite 603/604, Kennesaw, GA 30144; vicki@mydynamictherapy.com.

Patient Name: **Date:**

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have outside practitioners evaluate educational/cognitive functioning, feeding/swallowing function, academic performance and individual education plans), and we may use the results to help us reach a diagnosis and/or treatment plan of action. Many of the people who work for our practice – including, but not limited to, our therapists and administrators – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children, parents, respite care providers or individual case managers. Finally, we may also disclose your IIHI to other health care providers and educational teams for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

Patient Name: **Date:**

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

Patient Name: **Date:**

7. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Vicki Clarke, vicki@mydynamictherapy.com, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Vicki Clarke, vicki@mydynamictherapy.com.Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Vicki Clarke, vicki@mydynamictherapy.com, in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Vicki Clarke, vicki@mydynamictherapy.com. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Patient Name: **Date:**

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Vicki Clarke, vicki@mydynamictherapy.com. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before January 1, 2006.. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Vicki Clarke, vicki@mydynamictherapy.com. You will be offered a paper copy of this notice during your intial intake into our practice.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Vicki Clarke, vicki@mydynamictherapy.com. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Vicki Clarke, vicki@mydynamictherapy.com.

Patient Name: **Date:**