LBF SPEECH
COMMUNICATION CONSULTING SERVICES
AND
AGAPE THERAPY SERVICES
COMMUNICATION ACROSS THE LIFESPAN

Welcome to Agape Therapy Services! Thank you for choosing Agape Therapy Services to help meet your speech and language pathology needs. We realize there are many options from which to choose, and we appreciate the opportunity to assist you during this important process. Please fill out and return the following documents:

___ Adult Intake Form
___ Payment Policy and Agreement (Private-Pay Clients)
___ Assignment of Benefits (Insurance Clients)
___ Attendance Policy
___ Authorization for Release and Exchange of Information
___ Media Consent Form
___ Therapy Agreement
___ Informed Consent for Speech-Language Therapy
___ Client Notification of Privacy Policies (HIPAA Authorization)
___ Privacy Notice Acknowledgement
___ Teletherapy Consent Form

To proceed with scheduling of services, please fill out and complete the forms indicated above and return to: Agape Therapy Services, Attn: Leasonna Fuller Fax #: (210) 890-8988 or lfuller@agapetherapyservice.com If you have had any recent evaluations completed by other health professionals (psychologist, ENT, Oncologist, Gastroenterologist etc.), please bring copies of these with you or you may email them in advance at this email address: lfuller@agapetherapyservices.com

Leasonna Boozer-Fuller, M. A., CCC-SLP-Agape Therapy Services “Communication Across the Lifespan.”


**ADULT INTAKE FORM**

CLIENT INFORMATION:

Legal Name (on insurance card)_____
Preferred Name: _____ DOB: _____
Address:_____
City_____ State_____ Zip Code: _____
Phone 1 (Home) _____ Phone 2 (Cell)_____
Email:_____
Primary Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____
How did you hear about us? _____
Previous speech therapy evaluations/treatment and the agency/provider. ? If so, please list the month and year of evaluation

_____
_____
_____
_____
_____

Have you received ANY home health services this year including nursing? Yes_____
No_____ If yes, with which agency?

_____
When do you anticipate discharge? _____

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*Please be advised if you are receiving home health services, insurance will NOT cover outpatient services at the same time. If you do not disclose information regarding home health services and your insurance does not pay, you will be responsible for the balance.

What is your chief complaint regarding your speech, language, and/or swallowing skills?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Who noted the present problem? _____When? _____

Has there been any significant change in the last six months? _____ If so, what?

_____
_____
_____
_____
_____
_____

MEDICAL HISTORY: Please check if you have had any of the following and if so, when:

Seizures _____ High fevers_____ Chicken Pox_____ Whooping Cough_____ Pneumonia _____ Aspiration Pneumonia _____Tonsillitis____ Meningitis____ Encephalitis_____


Thyroid_____ Rheumatic Fever ____Tuberculosis_____ Sinusitis_____ Chronic Colds____
Enlarged Glands_____ Asthma/COPD_____ CHF_____ Throat Cancer _____GERD____
Vocal Cord Paralysis_____ Stroke_____ Traumatic Brain Injury_____
Explain any checked items here:

_____
_____
_____
_____
_____
_____
_____

Are immunizations current? Yes_____ No_____ Have you traveled outside of the U.S. within the past 60 days? Yes_____ No_____

CURRENT GENERAL HEALTH: Please indicate Yes or No; if Yes, please describe.
Allergies? Yes_____ No_____

_____
_____
_____
_____Food allergies? Yes _____ No_____
_____
_____
_____
_____Any other serious or recurrent illnesses? Yes _____ No _____
_____

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_____
_____
_____Any surgeries? Yes ____ NO____
_____
_____
_____
_____Any accidents involving head and/or neck trauma or loss of consciousness? Yes _____ No
_____
_____
_____
_____Any medications? If Yes, please list along with dosage and # taken per day (printed list acceptable)
_____
_____
_____
_____
_____Vision problems? Yes ____No____ If Yes, Past_____ and/or Current_____
Hearing difficulties: Yes_____ No_____ Hearing aids: Yes____ No_____
Dental problems? Yes_____ No_____ If Yes, please explain:
_____
_____
_____
Dentures: Yes_____ No_____ Does your dentures fit well?
_____

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OTHER INFORMATION: What goals would you like to achieve with therapy?

_____
_____
_____
_____
_____
_____

Anything else you would like us to know?

_____
_____
_____
_____
_____

CONTACT INFORMATION

At times, we may need to contact you for appointment reminders or other concerns. Please complete only the items below that you authorize as a method of contact. Note: Only one phone number and one e-mail address are required.

Home Phone: _____ Ok to leave message: Yes_____ No_____
Cell Phone: _____Ok to leave message: Yes_____ No_____
Email: _____Ok to email message: Yes_____ No_____
Emergency Contact: _____ Phone: _____
Relationship to Client: _____

INSURANCE/PAYMENT INFORMATION:

Primary Insured: _____DOB: _____


Primary Insurance Carrier: _____
Phone Number: _____
Billing/Claim Address: _____
City: _____ State:_____
ID #: _____Group #: _____
Secondary Insurance: _____
Policyholder Name: _____ DOB: _____ Phone Number: _____ Billing/Claim Address: _____ City: _____ State: _____
Policy Group or #: _____ Group #: _____

PAYMENT POLICY AND AGREEMENT (Private-Pay Clients) Thank you for choosing Speaking of the Matter Therapy Services as your service provider. We are happy to provide therapy services for you and your family. Please indicate the service requested and the method of payment below:

**Evaluation Services**

__The private pay rate of $175 for an adult speech-language evaluation will be charged to me. Payment is accepted in the form of cash, check, or debit/credit card. I am also responsible for these payments at the time of my visit.

**Therapy Services**

____The private pay rate of $100 per one-hour therapy session will be charged to me. Payment is accepted in the form of cash, check, or debit/credit card. I am also responsible for these payments at the time of my visit.

I AGREE AND ACCEPT THE ABOVE TERMS AND SERVICE AGREEMENTS.

Leasonna Boozer-Fuller, M. A., CCC-SLP-Agape Therapy Services “Communication Across the Lifespan.”


_____ _____

Client/Guardian Signature Date

_____

Client's Name (please print)

**ASSIGNMENT OF BENEFITS (Insurance Clients)**

***As a courtesy, we will verify your insurance benefits. However due to continuous inconsistent information provided by insurance companies, verification is NOT a guarantee of payment. Payment is ultimately the responsibility of the patient/guarantor. ***

I, _____, authorize the release of any payment and medical information necessary to process myself or my family member's insurance claim and related claims. I hereby authorize payment directly to LBF Speech Communication Consulting Services, PLLC of the insurance benefits otherwise payable to me for all professional services.

Signature of Policyholder:

_____Date:_____

**PARTY RESPONSIBLE FOR PAYMENT**

Name: _____ DOB: _____

SSN: _____

Address _____ Phone:

_____ Employer

Name:_____Phone:_____

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Employer Address:
_____

_____I have read and understand the payment policy. (Please Initial)

**PHOTOCOPY AUTHORIZATION**

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Client (Printed): _____ Date:
_____

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Client Signature: _____
Date_____

Legal Guardian (if applicable) Signature: _____ Date:
_____

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**ATTENDANCE POLICY**

Agape Therapy Services strives to ensure each client receives the services that best fit his/her needs and that progress is being made in therapy. Regular attendance at therapy sessions is imperative in achieving this goal. Therefore, Agape Therapy Services has the following policies regarding attendance:

I understand that a $40.00 fee may be charged for “no shows” and for cancellations made less than 24 hours before a scheduled appointment. I will receive notification of this fee via e-mail. If this fee is not paid in full within seven (7) days, my services will be put on hold until payment is received. I understand that this fee is not billable to any funding source and that this fee must be paid in order to continue services. _____ **Initials**


I understand that if I miss three (3) consecutive sessions (with the exception of serious illnesses or emergencies), I will be notified that I am in jeopardy of losing my appointment slot, and it may be given to someone else. _____**Initials**

I understand that if I miss a total of three (3) consecutive or non-consecutive sessions without calling 24 hours in advance to cancel the sessions (with the exception of serious illnesses or emergencies), I will be removed from my scheduled appointment slot and charged with cancellation fees for those sessions.

I understand that if I plan to go on a vacation and will be absent for two (2) or more weeks, I must notify the therapist at least a week in advance so that efforts can be made to reschedule my appointments. _____**Initials**
I understand if I am late to an appointment, the session will need to conclude at the usual time to allow the therapist to remain on schedule. If the therapist is running late for any reason, I will be given my full session time. Our staff regrets any inconvenience to our personal schedule, and we will make our best efforts to maintain timeliness. _____**Initials**

It is the responsibility of the client and the therapist to be respectful of health concerns. Clients who are sick should not be seen for therapy and therapists who are sick will not provide services to avoid spreading illness. If you are showing symptoms of illness on the day of an appointment or has exhibited vomiting and/or fever within the last 24 hours, please contact our office as soon as possible. Should the therapist become ill, you will be contacted to reschedule the appointment. _____**Initials**

Agape Therapy Services reserves the right to cancel or reschedule appointments in the event of inclement weather. Our goal is to keep our therapists safe on the roads. Many clients keep the


same appointment time each week, in which case it is understood that you will be seen at the same time on the following week. _____**Initials**

_____ _____

Client/Guardian Signature Date

_____

Client's Name (please print)

**AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION**

I hereby request and authorize the release and exchange of any relevant written or verbal medical, social, psychological, and/or test information you may have pertaining to:

_____ _____ _____

Client Name Date of Birth Legal Representative

The disclosure of this information is requested for the following purpose(s):

_____

____

Release To: Release From:

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Agency Name: _____ Agency Name: _____
Attention: _____ Attention: _____
Street Address: _____ Street
Address:_____ _____
_____
Phone: _____ Phone:_____

I understand that this consent is valid for one year from the date of signing and that I may revoke this consent at any time, by notification in writing to either of the named agencies. This revocation shall apply to both agencies except to the extent of action that has already been taken. I further release the agencies/persons and their associates from any liability arising from the release of this information or records to such designated persons or agencies.

_____ _____ _____
Client/Legal Representative Signature/Relationship Date

**MEDIA CONSENT**

Dear Clients,
We are updating our website and would like to include photos of our current clients while they are engaged in therapy sessions. Please read and sign below to grant LBF Speech Communication Consulting Services,PLLC the right to use photos of you for educational, therapeutic, or promotional reasons. I hereby grant full permission to LBF Speech Communication Consulting Services,PLLC to use my photograph in the following publication or advertising materials (printed or electronic, please circle):
• Website
• Posters

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- Brochure
- In-house educational purposes
- Interdisciplinary Collaboration/Educational Purposes
- Any and all
- None

_____ _____
Client's Name Date

_____ _____
Authorizing Guardian's Name (Please Print) Relationship to Client

_____
Phone Number

_____
Authorizing Signature

**THERAPY AGREEMENTS**

Therapy Sessions Therapy sessions are 30-60 minutes in length for all clients. If applicable and/or appropriate, caregivers will be called into room to speak with the clinician about the client's progress and homework during the last 5-10 minutes of the session. This is an important part of the treatment session as the client's progress is contingent upon the practice and carry-over that occurs in the home setting.
_____**Initials**

If you have specific questions, issues, or concerns that you would like to address, please let the clinician know at the beginning of the session, so that the proper amount of time can be allotted


to speak with you. If you do not notify the clinician at the start of the session that you are requesting additional time for questions, the clinician will have to address your questions at the next session. The clinician appreciates your understanding and compliance in helping us maintain timeliness for all of our scheduled appointments. _____**Initials**

Termination of Therapy The following reasons may be a cause to terminate our client contract:
• Behavior of a client (e.g., refusing to engage in therapy, refusing to follow directions or recommendations, verbal abuse, etc.). We anticipate and understand that all clients have “bad days,”; however, if the behavior is on-going, we may recommend a change in clinician. If the behaviors continue to persist after that point despite a variety of strategies implemented by the clinician(s), you will be referred to another facility
• Behavior of a caregiver
• Non-compliance with our attendance policy
• Repeatedly not paying your account balance. You will receive a warning when there is an outstanding account balance with multiple payments due. If we do not receive your payment within 7 days upon receipt of that warning, therapy will be placed on hold until payments are rendered in full. You may lose your appointment slot and be placed on a waiting list at that time. Continued non-payments will result in termination of services.
• Engaging in behavior that breaches trust such as withholding pertinent information about the case history or asking us to alter our data or diagnosis.

If you need to terminate therapy for any reason, we ask that you give us written notice a minimum of two (2) sessions in advance. This will allow us adequate time to wrap-up therapy and complete a consultation with you. A therapy termination form will be provided for you to complete. _____**Initials**

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LBF Speech Communication Consulting Services,PLLC reserves the right to cancel or amend this contract, or any part therein without negating the remainder of the contract. Clients will be notified, in writing, of any changes or cancellation of this contract. _____**Initials**

I have read and accept the terms of this contract.

Signed this _____ day of _____, _____.
(day) (month) (year)

_____ _____
Leasonna Boozer-Fuller, M.A., CCC-SLP Client/Guardian Signature
Owner, Speech-Language Pathologist
Client/Guardian

**INFORMED CONSENT FOR SPEECH-LANGUAGE THERAPY**

I, _____, the client hereby request and consent to LBF Speech Communication Consulting Services, PLLC to perform a screening and/or an evaluation and treat my disorder as prescribed by a physician and/or recommended by a speech-language pathologist.

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I understand and I am informed that, as in the practice of medicine, speech, language, and feeding/swallowing therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition, prior to treatment.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize LBF Speech Communication Consulting Services, PLLC to administer treatment under the direction and supervision of a certified speech-language pathologist.

_____ _____

Signature of Client Date

**CLIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA Authorization)**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Speaking of the Matter Therapy Services, LLC is dedicated to ensuring the privacy of your speech-language evaluation results and the course of therapy treatment. In serving our patients, we create records regarding treatment and services that are provided in order to have accurate information and to ensure the appropriateness and efficiency of treatment services. Federal law requires us to strictly protect any personally identifying information of yours. This notice


discloses our policies regarding the storage, use, and sharing of confidential patient information. PLEASE REVIEW THIS NOTICE CAREFULLY.

LBF Speech Communication Consulting Services, PLLC is required by law to keep your health information safe. This information may include:
· Notes from your doctor, teacher, or other health care provider
· Your medical history
· Your test results
· Treatment notes
· Insurance information

A government rule requires that you get a copy of this privacy notice. This rule is called the Health Insurance Portability and Accountability Act, or HIPPA for short. We will ask you to sign a paper acknowledging that you have been given this notice.

**How Your Health Information May Be Used or Shared**
We may use or share your health information for the following purposes:
1. **Treatment**: We may share your information with doctors or other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.
2. **Payment**: We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for therapy services. This may include sharing important medical information. We may share your information to: a) Receive the insurance company's permission to start treatment b) Receive permission for more treatment c) Receive compensation for the treatment you receive

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Your health information may be used or shared without your permission for the following:
· **Abuse and Neglect**: We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
· **As Required by Law:** We will share your information when we are told to by federal, state or local law. We will also share information if we are asked by the police or courts.
· **Government Functions**: Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
· **Information About a Person Who Has Died**: We may share information with the coroner, medical examiner, or a funeral director, as needed.
· **Health-Related Benefits and Services**: We may use your information to let you know of other services that might be of interest to you.
· **Public Health Risks**: We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
· **Regulatory Oversight**: We may use or share your information to report to agencies overseeing health care. This may include sharing information for audits, licensure, and inspections.
· **Threats to Health and Safety**: Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others.

**When Your Permission is Needed to Use or Share Your Health Information**
You must give us your permission to use or share your health information for any situation that is not listed on this notice. You will be asked to sign a form, called an authorization, to allow us to share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

**Your Privacy Rights**

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You have the right to:
· **Ask us not to share your information**: You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
· **Ask us to contact you privately**: You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call you but not email. Or you may want us to call you at work and not at home. You must ask in writing.
· **Look at and copy your health information**: You have the right to see your health information and get a copy of that information at any time. You have the right to see treatment, medical, and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
· **Ask for changes to your health information**: You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.

· **Get a report of how and when your information was used or shared**: You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this: o You need to ask us in writing. o You must tell us the dates you are asking about and if you want a paper or electronic copy.
· **Get a paper copy of this privacy notice**: You can get a paper copy of this notice at any time.
· **File complaints**: You can file a complaint with us or with the government if you think that a) Your information was used or shared in a way that is not allowed; b) You were not allowed to look at or copy your information; c) Any of your rights were denied

Who is C**overed by This Notice**

Leasonna Boozer-Fuller, M. A., CCC-SLP-Agape Therapy Services “Communication Across the Lifespan.”

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The people that must follow the rules of this notice are:
· All Speech-Language Pathologists at LBF Speech Communication Consulting Services, PLLC
· Anyone who is allowed to add health information to your file, including students and other staff
· Any volunteers who may help you while you are at this clinic/private practice

**Changes to the Information in This Notice**
We may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

**Complaints**
You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. All complaints must be in writing. You will not get in trouble for filing a complaint.

**Contacts** If you have any other questions about this notice or your privacy rights, please ask your Speech-Language Pathologist.

I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES DISCLOSED IN THIS NOTICE.

_____

_____
Client/Guardian Signature Date

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**PRIVACY NOTICE ACKNOWLEDGMENT**

LBF Speech Communication Consulting Services, PLLC is required by law to keep your health information safe. This information may include:

· Notes from your doctor
· Your medical history
· Your test results
· Treatment notes

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We are required by law to give you a copy of your privacy notice. Please retain a copy of this privacy notice for your records. This notice tells you how your health information may be used or shared. It also tells you how you can look at and comment on your information. By signing this page, you are saying that you have been given a copy of our privacy notice.

Client Name: _____

Client D.O.B: _____

Guardian Name: _____

Guardian Signature: _____

Date: _____

**TELETHERAPY CONSENT FORM**

The American Speech and Hearing Association (ASHA) defines telepractice ( the act of providing Telehealth services) as "the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation." This means that we are able to provide speech therapy services through digital meetings similar to the popular communication system “Skype”. While we do not specifically utilize skype for the provision of services, the method of delivery


would be similar in nature. The therapist and the child would join a computer based session at the designated therapy time, and would work on the same materials as in the office. We term this “teletherapy.” It is important to know that this service delivery model is supported through the Virginia licensing board, the American Speech-LanguageHearing Association (ASHA), and is payable by most insurance carriers per the Telehealth Enhancement Act of 2013- H.R.3306, 113th Congress. This mode of service delivery, when implemented correctly, is noted to have equal outcomes to face-to-face interventions.

I _____hereby consent to engage in teletherapy with LBF Speech Communication Consulting Services, PLLC.

I understand that “teletherapy” includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical information, both orally and visually. I understand the following with respect to teletherapy: I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of LBF, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. Agape and LBF currently use Doxyme to provide teletherapy services. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy

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sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. Teletherapy has been determined as an appropriate service delivery model for this patient. Teletherapy will only be used if determined to be at least as effective as in-person treatment. If teletherapy is not deemed as effective, you will be notified and referred back to in-person treatment. In order to participate in teletherapy, the patient must first participate in an in-person evaluation. For certain individuals, we ask that an adult facilitator be present in the room for assisting with technical difficulties, or keeping a child on task. Teletherapy may be used as the primary means of service delivery, or may be used in combination with in-person services.

I have read, understand and agree to the information provided above.

_____

Patient Name (Printed)

_____ _____

Patient / Guardian Signature Date