Long Island Speech Pathology Myofunctional Therapy Services P.C.
500 North Broadway Suite 141 Jericho, NY 11753
Phone: 516-597-4344 Fax: 516-597-4347

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 carefully.

1.) **Uses & Disclosures:** We will use my protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in my care. This may include doctors, nurses, technicians and other speech therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a physical therapist to address their physical limitations. The health information we share with the physical therapist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to my insurance company, including Medicare and Medicaid, so payments can be obtained for services rendered. My insurance company may make a request to review my medical record(s) to determine that my care was necessary.

Health Care Operations includes the utilization of my records to monitor the quality of care given at our facility or for business planning activities.

Other Special Uses: Our practice may use my PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law: The federal health information privacy regulations permit or require us to use or disclose PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object; we may use or disclose your PHI in an emergency situation, for research purposes (if we are provided with specific assurances that your privacy will be protected) or if we are required to do so by law (i.e., by court order or subpoena). Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.
We may use and disclose health information about you to avert a serious threat to the health and safety of you or others. If you are in the Armed Forces, we may release health information about you if deemed necessary by appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.
Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2.) **My Privacy Rights:**

Restrictions: You have the right to request a restriction on how your PHI is used; however, we are not required to agree with your request. If we do agree, we strongly abide by the request.

Confidential communications: You have the right to submit a written request for a confidential communication from us at a location of your choosing.

Access to PHI: You have the right to submit a written request for a copy of your medical record. We may charge a fee to cover the costs of copying and mailing.

Amendments: You have the right to submit a written request for an amendment to be made to your PHI if you disagree with its information about you and state why you believe it must be amended. If we disagree with you, we are not required to make the amendment. We may not amend parts of my medical record that we did not create.

Accounting disclosures: After April 14 of 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment or health care operations or for which we have obtained authorization.

Complaints: If you feel that my privacy rights have been violated, you have the right to submit a written complaint to us without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. You can also contact the Secretary of Health and Human Services.

Our duty to protect my privacy: We are required to comply with federal health information privacy regulations by maintaining the privacy of my PHI. We are required to provide you with our "Notice of Privacy Practices". We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice upon your next appointment with us.

Privacy Contact: If you would like more information about our privacy practices or to file a written complaint, you may contact:

Patricia Naglieri – Privacy Officer
Janine Stiene Speech Language Pathology, P.C.
Main Office: 213 Hallock Road, Suite 6
Stony Brook, NY 11790

RECEIPT OF PRIVACY PRACTICES

By signing on the lines below, I acknowledge that I have received and reviewed the "Notice of Privacy Practices".
If you have any questions, you can contact the practice/above privacy officer directly at (631) 689-6858.

_______________________________ Patient Name (printed)

_______________ Date

_______________________________ Patient Signature (18yrs and older)

_______________________________ Parent/Guardian Signature (if applicable)

Patient Responsibility Agreement
& Therapy Terms/Conditions

I, as myself, or as a representative for my child _________________________ would like to pursue all means necessary to obtain speech/language/feeding services for myself/my child.

I have a strong comprehension of my insurance policy and understand that even though "the center" has checked with my insurance company regarding my health coverage/benefits, the insurance company may have stipulations that are "interpreted" differently by each individual. I also understand that I am responsible for all referrals, at the time of my evaluation or session, if required by my insurance company. Furthermore, I understand that "the center" will submit all of the necessary paperwork and claim forms necessary for reimbursement. However, if the insurance company denies my claim, I will be responsible for the full cost of the evaluation. I am also aware that if I wish to continue services after my insurance benefits are exhausted, I will be responsible for a private fee, which is predetermined based on the treatment I/my child receives and due at the time of service.

All deductibles and co-insurance amounts for the visits are DETERMINED BY THE INSURANCE COMPANY. We are unable to quote an amount for the service. Co-payments may change BASED ON PROCEDURES. Changes in co-pay amounts may change as this is determined by insurance when claims are processed. A quote of benefits by your insurance company is NOT a guarantee of payment. Even after your pre-determinations or pre-authorizations are approved, your insurance states that payment is subjected to the terms and conditions of your policy. Your benefit overrides any pre-determination or pre-authorization approval.
Please keep in mind that all insurance plans are not the same and that you only have a certain amount of benefits per year. Not all plans extend their visits. If your benefits are combined with other therapies or rehabilitation services *(including, but not limited to : physical therapy, occupational therapy, post cochlear rehabilitation, cardiac and pulmonary rehabilitation, chiropractic care, cognitive rehabilitation, vision therapy, etc.)* you will need to keep count of your visits. We are unable to see your count down of visits from other facilities. If visits are exceeded, you will be responsible for payment. We will submit our claims to your insurance company. The co-insurance, co-pay, and deductible are amounts contracted between the patient and the insurance company. We are unable to negotiate these patient responsibilities***. For patients without insurance, any fees are due in full at the time of service.***
I understand that if I fail to submit payment to your office for services rendered, I will be responsible for the entire balance.

MISSED APPOINTMENT FEE –
*If you have a scheduled appointment that you will not be able to attend, you must contact the office 24 hours in advance or there will be a missed appointment fee applied.($40.00)

COPAYMENTS: Copayments are expected at the time of service along with any other payments (coinsurance or deductibles are billed separately). Any payment(s) requiring billing are subject to a $10 fee monthly. Should a debt remain unpaid, my account is placed in collections and I will be responsible to pay the full and entire fee for all services rendered, plus 25% collection fee and any legal costs in connection with collecting this debt.

PROFESSIONAL FEES- I am aware that my insurance company may send me payments for services rendered which includes evaluations and therapy. I also understand that in the event that the check is not immediately sent to my provider, I will be responsible to pay the full and entire fee for all services rendered, plus 25% collection fees and any legal costs in connection with collecting this debt.

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Patient Therapy Requirement Contract- I/We will be responsible for practicing regularly, which may mean up to three times per day and for as long as the therapist deems it necessary. In order for **me/my child** to master the techniques and skills taught during therapy, **I/we MUST** follow the rules and practice schedules outlined by my therapist. Furthermore, it will be **my/our** responsibility to schedule any and all reevaluations when informed by my therapist. **My/my child's** progress is directly related to the joint efforts of the therapist and **me/my family.**

-The goal of Janine Stiene's center for Speech-Language Pathology is to treat its patients with the utmost respect and consideration. The therapists promise to work diligently with me/my child to reach the goals that have been outlined.

-There are some disorders that cannot be ameliorated or corrected despite the therapists and my/my child's best efforts. If a therapist feels they cannot remediate **my/my child's** difficulties, he/she will consult with other therapists in the office to see if other considerations can be made to help with remediation. **I/We** understand that if all of the consulting therapists feel that **my/my child** have been treated using all of the therapists' best efforts to no apparent remediation, then the office promises to be forthright with that information and will not continue to see **me/my child** for therapy. Should the center no longer be able, despite their best efforts, to handle **me/my child's** behaviors or medical condition, the center will discuss and aid in the discontinuation of therapy and the referral of **me/my child** to a center better suited to handle such behaviors and/or medical conditions.

PATIENT VIDEO/PHOTOGRAPH AUTHORIZATION- As part of the evaluation and/or therapy process it is sometimes beneficial for a therapist to videotape/photograph you/your child during the evaluation or therapy session. This allows us to look back and review your/your child's difficulties and progress as therapy continues. In doing so, we are able to draw more accurate conclusions, provide appropriate treatment plans and goals. All of the above helps us to better understand what you/your child are experiencing.

By signing below, you will be giving authorization to the therapists of our centers to photograph/videotape you/your child as the therapist sees fit. These photographs/videos will be solely used for the purpose of assessing you/your child's difficulties, progress and for devising appropriate treatment plans. I understand that any photos or videos taken will be solely for therapy purposes only. I am also aware that for the safety of the staff and patients, all offices are monitored by cameras.

I understand therapy will be provided regularly, at my/my child's designated time, by a speech-language pathologist. The center guarantees that you/your child will be provided therapy by a qualified clinician at your designated appointment time*, however, the center will not guarantee a particular clinician.*

By signing below, I have read and understand all of the above terms/conditions.

Patient Name (printed): ___________________________________ Today's Date: _______________________

Your Full Name (printed): __________________________________ Your DOB: __________________________

Your Signature:____ Relationship To Patient: _______________________________

Your Address:____

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Combined Rehabilitative Services Document

Some insurance companies will group rehabilitative services such as physical therapy, occupational therapy, and speech therapy together while handling an individual's file. Therefore, it is important that Suffolk Center for Speech is aware of your status pertaining to these other rehabilitative services as they will impact your speech therapy visits.

(For yes or no questions, place an X on the correct answer)

- Are you currently being treated by an Occupational Therapist? Yes___ No___ If so, How often:________
- Are you currently being treated by a Physical Therapist? Yes___ No___ If so, How often:________
- Are you currently being treated by a Speech-language Pathologist? Yes___ No___
- Are you currently receiving Early Intervention Services? Yes___ No___

*If at any time you do seek occupational or physical therapy during your treatment at Suffolk Center for Speech, you must inform our billing department as to ensure your continued coverage on a per-visit basis by your insurance provider.

Payment is expected at the time of service unless other arrangements are made in advance of my visit. I authorize payment of insurance benefits directly to the physician for medical services provided. I further authorize the release of medical information necessary to process this claim. In the event that my insurance denies payment of a claim, either in whole or in part, I understand I am responsible for the payment in full.

I have ensured the necessary referrals for services have been obtained. If not, I understand I am responsible for all charges. By signing below, I am verifying that the above information provided is true, I have read, understand, and agree to all terms and conditions listed above.

Furthermore, I understand that by signing below, I will be considered the guarantor on file. Therefore, any/all fees incurred during the time you/the patient are seeking therapy, will be your responsibility. If you are not the guarantor, then you must have this signed and returned with the guarantor's information during subsequent visits in our office(s). If the guarantor is not changed, the responsibility of fees will continue to be the responsibility of the signee.

Signature(Parent/Guardian):____

Guarantor of Payment is:(Print)_______________________ (Sign):_______________________

Relationship to the Guarantor:____

Insurance Policy Holder:____

Date:_____________________

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HIPAA Compliant Authorization for Release of Protected Information

I, _________________________, authorize the release of my protected health information, or the information for ___________________________(minor child) as described herein. I understand that authorizing the disclosure of this information is voluntary.

I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

Please list any and all people who will be attending therapy with the patient, so that information regarding patient progress, goals and needs, may be shared with this person.

I authorize the following person(s) and/or organization(s) to receive my protected health information. Information regarding the patient goals, needs, concerns and future referrals, may be shared with the people below:

____ _______________________________
Name Relationship

____ _______________________________
Name Relationship

____ _______________________________
Name Relationship

I understand I have the right to revoke this authorization in writing at any time. I understand the revocation will not apply to any information that has already been released in response to this authorization.

____ _______________________________
Patient Name Date of Birth

____ _______________________________
Signature of Patient or Legal Representative Date