Capitol City
Speech Therapy, LLC
141 N Main Street
Fuquay-Varina, NC 27526
1520 Glenwood Avenue, Suite 201
Raleigh, NC 27608
Office: 919-577-6807 Fax: 919-577-6853
www.capitolcityspeechtherapy.com

Patient's Name

Date of Birth

Address

Permission to Evaluate at Treat

I hereby authorize Capitol City Speech Therapy (CCST) to evaluate/treat _____ (patient's name).

I understand that the results of the evaluation will be returned to the Client / Legal Representative, and the Physician referring the Client. I authorize CCST to release information, electronic or paper, about me as necessary to process claims for payment for services rendered, including health and liability insurance companies; agencies processing Medicare, Medicaid, or worker's compensation claims; medical benefit plans, case managers or reviewers; or third parties responsible for paying claims for services provided to me. I authorize payment for those services to be made directly to the provider or practice. I also authorize to be contacted via text, email, or standard mail to confirm appointments, provide therapy suggestions or any other pertinent information. I also agree NOT to video record during therapy sessions without written permission by my therapist.

As a courtesy, CCST will contact the insurance prior to initiating services and as needed throughout the course of treatment. Ultimately, I understand that it is my responsibility to determine and maintain insurance benefits. Benefits provided to me by CCST does not reflect a guarantee of payment by my insurance company for services rendered. I also understand that if I have a co-pay or a deductible to meet, I will make payment to CCST prior to evaluation and/or subsequent therapy sessions. This amount will be provided prior to the evaluation and/or therapy session. A receipt/invoice will be given at the time of payment. It is my responsibility to inform CCST of any changes to insurance, demographics, and/or name of Primary Care Physician thus if any expenses accrue because CCST was not notified I understand I will be responsible for payment of services.

CCST will send claims to the insurance company and wait for reimbursement. If the claim is denied based on the terms of the policy, CCST may require and/or request full payment of service rendered by the individual. We accept cash, Visa, Mastercard, Discover & personal checks. There is a return check fee. If payment is late, a 10% late fee will be added to the next bill. If you have not paid in full or arranged & honored a payment plan within 60 days, we will refer your account to a collection/audit bureau agency. They in turn will report your past due status to a Credit Report Agency. Any fees incurred by CCST for attorney costs will be your responsibility.

Medicaid Patients: _____ (Initial) Medicaid does not cover for the services provided on the same day by two different providers (i.e. speech therapy on the same day) or if services are provided by an out of network provider. Therefore, I understand it is my responsibility to pay for any expenses that accrue when Medicaid denies payment in these situations.

Medicare Patients: _____ (Initial) You must be discharged from any home health care services or agency prior to initiating outpatient therapy. If you begin to receive home health care services in the middle of your care with CCST, we must be informed immediately and be provided with the start date of your new home health care services. Our services will be terminated on or before that start date. Medicare will not pay for both home health (including Hospice Services) and outpatient care simultaneously.

"Information Blocking Rule": As a patient, I understand I have full access to any and all of my medical documentation completed by CCST in a timely manner. CCST will not block data sharing of HIPAA compliant documentation if it's requested by the patient (or legal

guardian). This information can be sent electronically or through patient portal free of charge. If I request medical records via paper, I understand that CCST will charge 25 cents per page to generate this request.

Acknowledgement of Receipt of Privacy Practices

I am aware of Capitol City Speech Therapy's notice of privacy practices and how they related to protection of personal health information. I am aware that at any time I can request current version or Capitol City Speech Therapy's notice of privacy practices.

_____ (Initial) I have received a copy of Capitol City Speech Therapy's notice of privacy practices.

OR

_____ (Initial) I was offered a copy of Capitol City Speech Therapy's notice of privacy practice, however, I declined a personal copy of this document. I am aware that at any time I can request current version or Capitol City Speech Therapy's notice of privacy practices.

COVID-19 Informed Consent to Treat

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. To proceed with receiving care, I confirm and understand the following:

I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.

I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.

I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office.

I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below and agree to reschedule treatment if I have experience any of the following symptoms 24 hours prior to my appointment:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. In addition, I agree to comply with preventative measures implemented by the staff which may include mandatory face coverings, temperature checks, hand washing and social distancing, as well as other recommended preventative measures.

Patient Last Name _____ Date of Birth: _____

Teletherapy Consent

American Speech and Hearing Association (ASHA) defines teletherapy (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 can provide speech therapy services through digital meetings. The digital media will be completed via synchronous telecommunications system which includes audio and video services that are **HIPAA complaint for PHI. The therapist and the patient 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 NC licensing board, the American Speech-Language-Hearing Association (ASHA) and is payable some 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 understand the following with respect to teletherapy:

I consent to engage in teletherapy with Capitol City Speech Therapy, 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 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 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 Capitol City Speech Therapy (CCST), 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.

I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment, and internet access for my teletherapy 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 to in-person treatment. 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.

**Exception: During COVID-19: Exception for COVID-19/HIPAA compliant technology might not be available: Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.

Media Consent

Purpose:

As part of our aim in offering a high-quality service, we have found it sometimes helpful to make full or partial recordings of sessions. Clinicians may utilize visual media in treatment session activities, or to communicate to caregivers not physically present in the session. It is also sometimes helpful in training new employees or students. Occasionally recordings are utilized to ensure accurate evaluation or assessment data.

Patient Last Name _____ Date of Birth: _____

On behalf of Capitol City Speech Therapy, in respect of any video/audio recordings made, every effort will be made to ensure professional confidentiality and that any use of visual media, will be for professional purposes only and in the interests of improving professional standards. Every effort will be made to protect the anonymity and privacy of all those involved in the sessions.

In addition, parents or families must have verbal consent from the treating therapist before taking any videos or pictures within the session for each instance.

Consent:

I, _____, on behalf of my child, _____, voluntarily and without compensation authorize Capitol City Speech Therapy permission to utilize visual and auditory media during the session. I understand that my child's voice and/or photo (including face) may be included. I give permission for photographs and videos may be shared with the following conditions:

_____ (initial) I authorize use of video, audio, or photos for the purposes of therapy activities, evaluation and assessment, communication with family and caregivers, in house training or consultation within CCST, or collaboration with other professionals for whom a signed authorization of release is on file. I authorize sharing of media for these purposes via print, text, unencrypted email, voicemail, and apps.

_____(initial) I authorize use of video, audio, or photos of my child for the purposes of promotional material which may be shared in print, social media, website, or presentations in the community.

OR
Decline:

I _____ choose not to give permission for the Speech Therapy Services to use photographs, audio recordings and/or video recordings of my child, _____.

By signing this form, it indicates that I have read and fully understand the terms listed above in **Permission to Evaluate at Treat, Acknowledgement of Receipt of Privacy Practices, COVID-19 Informed Consent To Treat, Teletherapy Consent, Media Consent**. This document has also been explained to me, and I fully understand all terms and responsibilities.

Signature of Client/Legal Representative Relationship Date

Printed Name of Client/Legal Representative

Patient Last Name _____ Date of Birth: _____

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Authorization for Release of Information from Capitol City Speech Therapy

I hereby consent to and authorize Capitol City Speech Therapy to RELEASE information about patient to individuals/facilities listed below. (Please include medical or therapy providers as well as family or caregivers involved in treatment i.e. grandparents, nanny, neighbors, etc.):

Patient Name			
Date of Birth			
Name of facility/individual	Relationship	Name of facility/individual	Relationship
Name of facility/individual	Relationship	Name of facility/individual	Relationship
Name of facility/individual	Relationship	Name of facility/individual	Relationship

Specific Information Being Released includes:

_____Speech-Language Evaluations
_____Speech-Language Discharge Summaries
_____Speech-Language Progress notes
_____Speech-Language Therapy Notes
_____CBRS progress notes
_____Pertinent Therapeutic Information
_____Audio recordings
_____Video recordings
_____other: _____

The purpose of sharing this information is for continuity of care.

I hereby release, discharge, and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information. I understand that I may revoke this consent at any time excluding any information that has already been released. Without my expressed revocation, this consent will expire one year from date of signature.

I understand release of my medical information may include transferring copies of my medical records by mail, phone, voicemail, facsimile (FAX) machine, or encrypted document via e-mail. It is understood that transfer of information by using electronic equipment and the potential for error increases when complicated pieces of equipment are involved. It is understood that this type of information transfer includes the possibility that records may arrive at a destination other than the intended destination.

Signature of Client/Legal Representative	Relationship	Date
Printed Name of Client/Legal Representative		

Patient Last Name _____ Date of Birth: _____

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Request of Information

I hereby consent and authorize release of my medical information FROM the agency below TO Capitol City Speech Therapy:

Patient Name

Date of Birth

Address

Name of Facility/Doctor

Dates of Service

Specific Information Being Requested includes:

_____Speech-Language Evaluations
_____Speech-Language Progress notes
_____ENT Consultation/Audiology reports
_____PT/OT Evaluation
_____Individualized Education Plan (IEP)
_____other_____

_____Speech-Language Discharge Summaries
_____Speech-Language Therapy Notes
_____Pertinent Therapeutic Information
_____Neurological Evaluation
_____Psychological Evaluation

The purpose of this information is needed for continuity of care.

I hereby release, discharge, and agree to hold harmless all parties, specified below, to whom this consent is given from any liability that may arise from the release of information.

I understand that I may revoke this consent at any time excluding any information that has already been released. Without any expressed revocation, this consent will one year from date of signature.

I understand release of my medical information may include transferring copies of my medical records by mail, phone, voicemail, facsimile (FAX) machine, or encrypted documents via e-mail. It is understood that transfer of information by using electronic equipment and the potential for error increases when complicated pieces of equipment are involved. It is understood that this type of information transfer includes the possibility that records may arrive at a destination other than the intended destination.

This document has been explained to me and I understand it.

Signature of Client/Legal Representative Relationship Date

Printed Name of Client/Legal Representative