19100 W. Lake Houston Pkwy., Suite #104Humble, Texas 77346
Phone: (281)812-9519 Fax: (281) 812-5719 Email: Info@AchieveSLS.com

Dear Patient and Family,

Welcome to Achieve Speech & Language Services! Achieve is pleased to offer the highest quality speech therapy services, integrating the most up-to-date treatment techniques with a family-centered approach. Achieve believes considering the child's family life, school environment, self-esteem, and emotional development are vital for effective treatment.

If at any time questions or concerns arise, please notify a therapist or the front desk and a representative would be happy to help. Our intention is for a positive experience for everyone at Achieve, which is why we support an encouraging, family-centered environment.

Sincerely,

Achieve Staff

Insurance Information

- **HOW IS EACH SESSION BILLED TO MY INSURANCE COMPANY?** As is current practice in the field, speech pathology services have been and will be billed according to the American Medical Association's Current Procedural Terminology (CPT) codes. These are approved and accepted descriptions of procedures that are performed during each therapy session. Each code has its own cost based on the skill of the procedure. Our fee schedule is based on industry standards and contract rates, and is updated on a yearly basis.

- **WHAT IS THE AVERAGE COST OF EACH SESSION?** Depending on what procedures are performed, an average therapy session can range anywhere from $80.00–450.00 Evaluations and assessments are usually more expensive due to the level of skill and the significant time commitment needed by the therapist to complete a thorough evaluation and report.

- **WHY DO I SEE TWO PROCEDURES FOR ONE DATE OF SERVICE?** What you are seeing is an office visit procedure, just as you would when visiting the doctor, in addition to the specific therapy procedure. An office visit procedure is also completed during an evaluation as well as a trial treatment to judge appropriateness for therapy.

- **HOW IS MY CO-PAY/CO-INSURANCE DETERMINED AND WHEN IS IT DUE?** Each insurance policy is different. You may have a "co-pay", which is a standard amount of money due at each office visit, or you may have a "co-insurance" which is a percentage of the amount billed for that therapy session. Our billing department would be happy to assist you in determining what your responsibility is for each session. Both co-pays and co-insurance amounts are due at the time that services are rendered.

- **AM I RESPONSIBLE FOR MY DEDUCTIBLE?** Yes. At the beginning of each coverage year, patientsare responsible for their health insurance deductible. This obligation usually begins in January; however, please check with your company's Human Resource department or your insurance provider to see when your benefit-year begins. The amount of your deductible depends upon your individual insurance policy and whether we are an in-network or out-of-network provider. The fee for each therapy session will be due in full until this deductible amount is met. Our billing department would be happy to assist you in determining what your responsibility is for each session.

- **AM I RESPONSIBLE FOR FEES THAT ARE REDUCED BY MY INSURANCE COMPANY?** No. Fees are reduced either because of "usual and customary" charge amounts or because of a pre-determined fee schedule mutually agreed upon in our network contract with the patient's insurance company. These charges should not be listed under "patient responsibility" on your explanation of benefits.

- **AM I RESPONSIBLE FOR CODES THAT ARE DENIED BY MY INSURANCE COMPANY?Yes.** We would be happy to provide documentation and/or letters of support to appeal denied codes. We will also make every effort to resubmit alternative procedural codes. However, **patients are ultimately responsible for any charges not covered by their insurance company**. We urge you to actively participate in the denial process by calling your insurance company to check the status daily.

- **WHAT IF MY INSURANCE BENEFITS RUN OUT?** After consulting with your therapist and determining the need for continued services, we will make every effort to provide you with the documentation necessary to assist you in an appeal process. However, it is the insured's responsibility to appeal any limitations placed on policy benefits. It is also the insured's decision whether to continue services during this process or not, but the patient will be ultimately responsible for all charges if an appeal is denied.

- **HOW OFTEN WILL I RECEIVE A STATEMENT?** Statements are provided upon request. These statements reflect all account activity from the month prior including both charges and payments. Please do not hesitate to contact our billing department with any questions or concerns regarding your account.

- **EXPEDITING YOUR COVERAGE:**You are the policyholder. As such, the insurance companies pay more attention to you than they do to us. You have chosen their company and pay premiums to them specifically to pay for your services. It often becomes necessary for families to advocate on their own behalf. Again, **we encourage you to participate in any denials or discrepancies with your insurance company.**

Financial Responsibility Policy

Payment is required at time of service. If for any reason we are unable to verify insurance eligibility prior to office visit, ***the patient is responsible*** for full payment upon services being rendered. The patient is responsible for the full balance due if insurance does not provide coverage for speech therapy or fails to pay the amount in full. Please come to the window to make payments each session.

Verification of benefits is not a guarantee of payment. The patient accepts responsibility for the initial authorization required by your insurance company and any charges not covered by your insurance. Benefits are subject to eligibility at the time of service. All specific plan provisions, exclusions and limitations will be applied at the time the claim is processed.

PAYMENT FOR DENIED OR NONCOVERED SERVICES
If a patient's insurance company denies or considers a procedure a non-covered service the patient is responsible for immediate paymentof all the billed services. Procedures or services would include evaluation, treatment, or office visit. All patients will be required to have a credit card authorization on file so that a credit card may be billed for any outstanding balances if necessary.

I understand **I am responsible** and will pay for all the following charges before my child or I attend the next therapy session:

CO-PAYMENTS – due at time of service (please come to window to pay)
NO-SHOWS or LATE CANCELLATION - $80
RETURNED CHECK - $35.00/check
CHART COPIES - $10

I understand and agree that in consideration of services to be rendered to the patient, I individually obligate myself to pay the account of Achieve Speech & Language Services, PLLC, in accordance with the regular rates and terms of Achieve Speech & Language. I acknowledge my understanding that I am responsible for all charges that are not covered by my insurance carrier. I understand that I am responsible for paying any deductibles, co-pays, or non-covered services by my insurance carrier, as dictated by my health insurance policy.

Cancellation Policy

Our goal at Achieve Speech &Language Services, PLLC, is to ensure positive therapeutic outcomes for every child. Regular attendance for therapy sessions is crucial to accomplish this goal. Every attempt is made to schedule your services in a timely manner and at your convenience. However, we cannot reserve therapy time for persons who do not maintain consistent attendance. As such:

CANCELLATIONS

- **All cancellations must be made at least 24 hours in advance.**

We know that unexpected illness or events may occur that prevent this; therefore, in these circumstances, we ask that you make cancellations at least the morning prior to your scheduled treatment session. Any cancellation made in less than 24 hours is considered a **late cancellation.** A patient may be subject to lose their therapy time if cancellations become chronic.

NO-SHOWS

- **No–shows** (without anyadvance notice) will be charged a regular session fee of $80, which is due prior to your next appointment. You may reschedule a no-show nullifying the cancellation fee if an appointment can be rescheduled(subject to therapist availability) no later than **Friday** of the same week. Insurance companies do not cover no-show charges.
- Clients who routinely miss their scheduled appointments **with or without** notifying our office will be subject to automatic discharge from therapy services. In the unfortunate event that this occurs, notification will be provided.

PUNCTUALITY

- Due to scheduling constraints and in respect to later clients' and therapists' schedules, a client's designated therapy session will end promptly at its assigned time.

Exceptions to the aforementioned policies are considered on a case-by-case basis. If you have questions or feel you have a situation that requires special consideration, please contact your clinician as soon as possible. We truly appreciate your assistance in meeting these goals.

Complaint Policy

If you have a complaint about services received in this clinic, please notify the front office so that we may address your concern as soon as possible. If you feel that Achieve Speech and Language has not adequately resolved your concern, you may make a complaint as an individual to either The State Board of Examiners for Speech-Language Pathology and Audiology or The Executive Council of Physical Therapy and Occupational TherapyExaminers.

The State Board of Examiners for Speech-Language Pathology and Audiology was created administratively within the Department of State Health Services (DSHS). Complaints are filed with the Investigations and Quality Assurance Unit. An individual who wishes to file a complaint against a speech-language pathologist, audiologist, intern, or assistant may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas78714-1369

Assignment of Payment Rights: Allowing My Insurance Company to Pay Achieve Directly

I understand that this assignment of benefits allows that healthcare providers of Achieve Speech & Language Services, PLLC, be paid directly by my health insurance carrier or other health benefit plan for the services the healthcare providers provide to me, my minor dependent, or other person entitled to health care benefits. In return for the services rendered and to be rendered by the healthcare providers, I hereby irrevocably assign and transfer to the healthcare providers all right, title, and interest in benefits payable for the health care rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. I agree and acknowledge that my signature on this document authorizes Achieve Speech & Language Services, PLLC, or its designee, to submit claims for professional services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted on the patient's behalf.

This assignment and transfer shall be for the purpose of granting the healthcare providers an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the healthcare providers to pursue any such right of recovery. In no event will the healthcare providers retain benefits in excess of the amount owed to the healthcare providers for care and treatment rendered. Should the benefit plan, an ERISA plan, local, state or federal agency or program be non-assignable for any reason, I hereby specially direct that the third-party payor send payment for any benefits to be paid for care provided to me or my minor dependent by Achieve Speech and Language Services, PLLC to my attention at the above address. By sending payment in this manner, I release the third-party payor of any liability under the plan or policy to the extent of payments made. I agree that this authorization will cover assignment of benefits for all professional medical services rendered by Achieve Speech and Language Services, PLLC until such authorization is revoked by me in writing. I agree that a photocopy of this form may be used in lieu of the original.

Consent to Use Client's Likeness

By signing the document, I give my consent, as a parent/guardian to Achieve Speech & Language Services, PLLC, to use my child's likeness (photograph, video, voice) for use in the course of reasonable and necessary evaluation, treatment, continuing education, or marketing. I offer the use of my child's likeness to Achieve Speech & Language free of charge. I understand that I may deny consent for Achieve Speech & Language to use my child's likeness at any time by giving a written notice. I understand that Achieve Speech & Language maintains compliance with all medical privacy and confidentiality laws and standards and will not disclose my child's name or identifying information.

Release of Liability and Emergency Medical Treatment

By signing this document I understand as parent/guardian, I am responsible for my child's behavior and safety while on the premises of Achieve Speech & Language Services, PLLC. I agree to hold Achieve Speech & Language its employees and agents harmless in the event of any accident or injury that occurs on Achieve Speech & Language premises, as a result of lack of parental/caretaker supervision or my child's misbehavior.

Further, I understand that if I leave the premises while my child is receiving therapy, I must be immediately available by either cell phone or pager. I agree to notify my therapist and the office staff each and every time before leaving the premises.

I understand that in the event of a medical emergency, the staff of Achieve Speech & Language will call 911 for emergency medical treatment.

Privacy Notice: Keeping Your Medical Information Private

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within this clinic for the purposes of treatment, payment and healthcare operations.
- Your confidential healthcare information may be released to your insurance provider for the purposes of treatment, payment and healthcare operations.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providersfor the purposes of treatment, payment and healthcare operations or in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may **not** be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you as indicated by your signature below. You may revoke permission to release confidential healthcare information at any time.
- You may be contacted by the clinic to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to restrict the use of your confidential healthcare information. However, the clinic may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information. Chart copy fee of $10 applies.
- You have the right to make addendums to your healthcare information.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The clinic is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- The clinic will abide by the terms of this notice. The clinic reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to the clinic privacy officer if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the clinic:

Achieve Speech & Language Services,PLLC
19100 W. Lake Houston Pkwy, Ste 104
Humble, TX 77346

- All complaints will be investigated. No personal issue will be raised for filing a complaintwith the clinic.
- For further information about this Privacy Notice, please contact:
  - Privacy Officer – Kandy Jenks
  - 281-812-9519
- This notice is effective as of June 5, 2007

Patient Rights and Responsibilities: Your *Achieve* Bill of Rights

RIGHTS

1. Access to Care: Individuals shall be accorded impartial access to treatment or accommodations as to their requests and needs for treatment or service that are within the clinic's capacity, availability, stated mission and applicable law and regulation, regardless of race, creed, sex, national origin, religion, disability or source of payment of care.
2. Respect and Dignity: Every individual, whether adult, adolescent, child or newborn, has the right to considerate, respectful care at all times and under all circumstances, with recognition of their personal dignity, and psychosocial, spiritual and cultural variables that influence their perceptions of illness.
3. Privacy and Confidentiality: The client (or hereinafter his/her parent or legal designated representative) has the right within the law, to personal and informational privacy, as manifested by the right to:
    a. Receive appropriate treatment in the least restrictive setting available.
    b. Refuse to talk with or see anyone not officially connected with the clinic, including visitors, or persons officially connected with the clinic but not directly involved in his/her care.
    c. Wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatment.
    d. Be interviewed and examined in surroundings designed to ensure reasonable audiovisual privacy this includes the right to have a person of one's own sex present, if requested, during certain parts of a physical examination, treatment or procedure performed by a health professional of the opposite sex and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which the client was asked to disrobe.
    e. Expect that any discussion or consultation involving the client's case, whether adult, adolescent, child or newborn, will be conducted discreetly and that individuals not directly involved in their care will not be present without his permission.
    f. Review his/her medical records and have the information explained, except when restricted by law.
    g. Have the medical records read only by individuals directly involved in the treatment or the monitoring of its quality and by other individuals only on the client's (or her parent or legal designated representative's) written authorization. When the records are released to insurers, that confidentiality is emphasized.
    h. Expect all communications and other records pertaining to care of the individual, including the source of payment for treatment, to be treated as confidential.
    i. Request a transfer to another treatment room if another client or visitor is unreasonably disturbing him/her.
    j. Be placed in protective privacy when considered necessary for personal safety.
4. Personal Safety: The client has the right to expect reasonable safety insofar as the clinics practices and environment are concerned. A humane treatment environment that provides reasonable protection from harm and appropriate privacy for personal reasons.
5. Identity: The client has the right to know the identity and professional status of individuals providing services and to know which physician or other practitioner is primarily responsible for his care. This includes the right to know of the existence of any professional relationship among individuals who are treating him as well as the relationship of the clinic to any other health care or educational institution involved in his care. Participation by clients in clinical training programs or in the gathering of data for research purposes should be voluntary.
6. Information: The client has the right to obtain from the practitioner responsible for coordination of his/her care complete and current information concerning their diagnosis (to the degree known), treatment and any known prognosis. This information should be communicated in terms the client (or her parent or legal designated representative) can reasonably be expected to understand. When it is not medically advisable to give such information to the client, the information should be made available to a legally authorized individual.
7. Communication: The client has the right of access to people outside the clinic by means of visitors and by verbal and written communication. The client who does not speak or understand the predominant language of the community should have access to an interpreter. This is particularly true where language barriers are a continuing problem.
8. Consent: The has the right to the information necessary to enable him, in collaboration with the health care practitioner, to make treatment decisions involving his health care that reflects his wishes. To the degree possible, consent should be based on a clear, concise explanation of the condition and of all proposed technical side effects, problems related to recuperation and probability of success. The client should not be subjected to any procedure without voluntary, competent and understanding consent by the individual. Where a medically significant need for care or treatment exists, the client shall be so informed. The client has the right to know who is responsible for authorizing and performing the procedures or treatment.The client shall be informed if the clinic proposes to engage in or perform research/educational projects affecting his care or treatment and the client has the right to participate in any such activity. If the client chooses not to take part, he shall receive the most effective care the clinic otherwise provides.
9. Consultation: The client has the right to accept medical care or to refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. When refusal of treatment by the client or his parent or legal designated representative prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the client may be terminated upon reasonable notice. The client has the right for an individualized treatment plan and to participate in the development of the plan.

10. Transfer and Continuity of Care: A client has the right to expect that the clinic will give necessary health services to the best of its ability. Treatment referral or transfer may be recommended. If transfer is recommended or requested, the client will be informed of risks, benefits and alternatives. The client will not be transferred until the other institution agrees to accept the client.
11. Charges: Regardless of the source of payment for the individual's care, the client has the right to request and receive an itemized and detailed explanation of the total bill for services rendered in the clinic. The client has the right to timely notice prior to termination of his eligibility for reimbursement by any third-party payer for the cost of this care.
12. Delineation of Client's Rights: The rights of the client may be delineated on behalf of the client, to the extent permitted by law, to the client's guardian, next of kin or legally authorized responsible person if the client:
    a. Has been adjudicated incompetent in accordance with the law; or
    b. Is found by her physician to be medically incapable of understanding the proposed treatment or procedure; or,
    c. Is unable to communicate her wishes regarding treatment; or,
    d. Is a minor.

RESPONSIBILITIES

1. A client has the responsibility to provide, to the best of her knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications and other matters relating to her health. She has the responsibility to report unexpected changes in her condition to the responsible practitioner. A client is responsible for making it known whether he clearly comprehends a contemplated course of action and what is expected of him.
2. A client is responsible for following the treatment plan recommended by the practitioner primarily responsible for his care. This may include following the instructions of health care personnel as they carry out the coordinated plan of care and implement the responsible practitioner's orders and as they enforce the applicable rules and regulations.
3. The client is responsible for keeping appointments and, when he is unable to do so for any reason, for notifying the responsible practitioner or the clinic.
4. The client is responsible for his actions if he refuses treatment or does not follow the practitioner's instructions. If the client cannot follow through with the treatment, he is responsible for informing the physician.
5. The client is responsible for ensuring that the financial obligations of his health care are fulfilled as promptly as possible. The client is responsible for providing information for insurance.
6. The client is responsible for following the clinic's rules and regulations affecting client care and conduct.
7. The client is responsible for being considerate of the rights of other clients and personnel and for assisting in the control of noise. The client is responsible for being respectful of the property of other persons and of the clinic.

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Acknowledgment of Receipt of Patient Handbook

I have read and acknowledge receipt of the patient handbook. **By *initialing each section* below, I agree to adhere to all Achieve Speech & Language Services policies and procedures.**

_____ Insurance Information

_____ Financial Responsibility

_____ Cancellation/Attendance Policy

_____ Complaint Policy

_____ Assignment of Payment Rights

_____ Client's Likeness

_____ Release of Liability

_____ Privacy Notice

_____ Patient Rights/Responsibilities

_____
Patient's Name

_____ _____
Signature of Parent or Responsible Party Date

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SECURE AUTO PAY AUTHORIZATION FORM

**Required for Private Pay

Circle one: American Express MasterCard Visa Discover

Patient Name: _____

Cardholder Name: _____

Credit Card #: _____

Expiration Date: _____

Billing Zip Code: _____

Card Security Code: _____

Cardholder Signature: _____

I understand this allows Achieve Speech and Language to securely and automatically charge my weekly or monthly balance to this credit card to cover private pay, co-pays, co-insurances, and/or deductibles. The amount will not exceed $_____.

Please bill my credit card: **(Please initial below.)**

_____Monthly _____Weekly

** Auto pay is REQUIRED if you are not billing insurance (private pay). Please see your therapist or the front desk with any questions or concerns.

ACHIEVE
SPEECH AND LANGUAGE

19100 W. Lake Houston Pkwy., Suite #104 Humble, Texas 77346
Phone: (281) 812-9519 Fax: (281) 812-5719 Email: Info@AchieveSLS.com

Release of Information by the Insurer to Achieve for the Purposes of Treatment, Payment, and Healthcare Operations

I hereby authorize any third-party payor, including but not limited to insurance companies, employee benefit plans, ERISA plans, local, state and federal government agencies to freely communicate with Achieve Speech and Language Services, PLLC, or its agent or representative, as to any information which, in any way, may relate to a claim submitted for reimbursement by either me or Achieve Speech & Language. This includes, but is not limited to all information which might relate to any decision rendered in regard to any appeal filed on a claim submitted for reimbursement of any medical care of any kind rendered on behalf of myself or my minor dependent. I further authorize any health care provider who has provided care to me or my minor dependent release to Achieve Speech & Language, or its agent or representative, information regarding care they have provided to me or my minor dependent which that medical office believes is necessary to submit to any third-party provider in the processing of a claim for reimbursement.

I authorize Achieve Speech & Language, or its agent or representative, to release information acquired in the course of my examination or treatment to healthcare providers and to healthcare providers' billing services, insurance companies (or their agents) for reimbursement purposes, and federal and state health care agencies in accordance with applicable law. I understand that the specific information to be disclosed may include history of drug and alcohol abuse, mental health treatment, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), laboratory tests results, treatment progress, and any other such related information. I agree that this authorization will cover professional medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original.

_____
Patient's Name

_____ _____
Parent/Guardian Signature Date

19100 W. Lake Houston Pkwy., Suite #104 Humble, Texas 77346
Phone: (281) 812-9519 Fax: (281) 812-5719 Email: Info@AchieveSLS.com

Release of Information to Family Members/Guardians

I hereby authorize Achieve Speech & Language Services to share information:

please check one or both

- o regarding my child's therapy activities/homework

  Please list persons (i.e. family members/caregivers) with which the checked information may be shared:

  _____

  _____

  _____

- o regarding my insurance, billing and/or statement charges

  Please list persons (i.e. family members/caregivers) with which the checked information may be shared:

  _____

  _____

  _____

If there are any unusual circumstances related to custody, guardianship, or foster placement, please provide copies of the legal documents.

_____
Patient Name

_____ _____
Parent/Guardian Signature Date