SEA LION SPEECH THERAPY
SPEECH + LANGUAGE + LITERACY

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857-303-0355

TREATMENT POLICIES AND PRIVACY PRACTICES

General Policies

Each speech therapy treatment session occurs for 45 minutes, with 10 minutes for family-therapist connections, questions, and clean-up. Evaluations typically last 1 hour (speech only) to 3 hours (language and literacy).

We ask that a legal guardian, relative, or caregiver be within reach during all evaluation and treatment sessions. In case you need to step out, we ask that you provide a number where you can be reached in an emergency.

Evaluations and therapy will need to be provided in a quiet spot where your child feels comfortable. Often, the kitchen table, an office, or the living room works well. Some children benefit from parent involvement during sessions, and some do better with less distractions. Therapist and family members will need to decide what arrangement works best for optimal treatment.

All necessary diaper changes, clothing changes, and bathroom breaks will be facilitated by the child's legal guardian, relative, or caregiver.

Cancellation Policy

If you need to cancel an appointment, please call/text (857) 303-0355 or email sealionspeech@gmail.com at least **24 hours** prior to your appointment for all scheduling/cancellation/rescheduling matters. **A late cancelation or no-show fee of $40 will be charged to the card on file.**

Sometimes, illness happens suddenly. Please let us know as soon as you realize your child is developing symptoms. If your child is too sick to go to school, he/she is too sick to have speech therapy.

Please call or email to cancel if your child is showing any of the following:

- fever, diarrhea, vomiting, head lice, elevated temperature, eye or nasal discharge, thick mucus or drainage from the nose or eye(s), or pink eye.

Inclement Weather Policy

In the event of poor weather, Sea Lion Speech will cancel evaluations or therapy in line with Seattle Public School Districts. Please contact us with questions regarding therapy if weather near your address is a concern.

Payment Policy

Payment is due in full at time of service. If billing insurance, applicable co-pays invoices will be sent monthly. Accepted forms of payment include cash, check, or credit card. Unless a payment plan is specifically discussed, your credit card will be kept on file and charged at the time of service. Payment by credit card will incur a 3% processing fee.

Fees for speech-language pathology services with Sea Lion Speech are as follows:

- **Treatment sessions:** $120.00 per session
- **Meetings/consultations with parent and/or school:** $120.00 per 50 minutes
- **Telephone consultations with parent:** $30.00 per 30 minutes, after the first 15 minutes
- **Speech and Language Evaluation:** $300.00
    - Includes analysis, written report, and up to 1-hour consultation with legal guardian
- **Speech Only Evaluation:** $200.00
    - Includes analysis, written report, and 30 minute consultation with legal guardian
- **Language and Literacy Evaluation:** $650.00
    - Includes analysis, written report, and up to 1-hour consultation with legal guardian

Additional fees:

- $5.00 travel fee per in-home visit to cover car mileage, time, and bridge fees
- 3.5% processing fee for credit card payments through Square (payment by check or direct transfer available through some banks does not incur a processing fee)

Sea Lion Speech is an in-network provider with Regence Blue Shield and Premera but may be considered an out-of-network provider for some insurances. Superbill invoices are available upon request for you to submit to insurance.

Clients are encouraged to contact their insurance provider regarding pre-authorization, yearly therapy limits, and coverage rates of the following CPT-codes:

- **92522-** Evaluation of speech sound production
- **92523**- Evaluation of language comprehension and expression (e.g., receptive and expressive language) with evaluation of speech sound production (e.g.,articulation, phonological process, apraxia, dysarthria).
- **92507-** Speech, language, and social communication treatment.

Rates are subject to change upon two weeks of written notice. Overdue bills past 30 days will be charged to the card on file and/or sent to collections with added costs as allowable by law.

Please return this entire document to us with your signature. We will give you a copy for your records.

The above policies become effective as of the date of signature below. These policies supersede any previous policies, both verbal and written. **I have read and agree to these policies.**

_____ _____

PRINT NAME OF CLIENT DATE

_____ _____

PRINT NAME OF LEGAL GUARDIAN SIGNATURE OF LEGAL GUARDIAN

HIPPA POLICY

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 it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical Examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your Authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of December 12, 2018 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact the following for more information:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Acknowledgement That You Have Received Our HIPAA Privacy Notice

This acknowledgement is required by law to keep your health information safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

HIPAA Privacy Notice Acknowledgement
Please initial the following statements.

	I acknowledge that I have received a copy of Sea Lion Speech/Megan Pattee HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.
	I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.
	I understand Sea Lion Speech/Megan Pattee cannot disclose my health information other than as specified in the notice.
	I understand that Sea Lion Speech/Megan Pattee reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____

PRINT NAME OF CLIENT DATE

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PRINT NAME OF PARENT OR LEGAL GUARDIAN

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SIGNATURE OF PARENT OR LEGAL GUARDIAN

Please Note: It is your right to refuse to sign this acknowledgment