TalkAbout, inc.

Speech and Language Therapy
Occupational Therapy
1327 Kalakaket St Fairbanks, AK 99709
Phone 907-452-4517 Fax 907-452-4263

CHILD REGISTRATION FORM

CHILD'S NAME _____ **CHILD'S Date of Birth** _____ **M ☐ F ☐**
(Last, then First)

REGISTERING PARENT/GUARDIAN:

PARENT / GUARDIAN NAME _____ RELATIONSHIP TO PATIENT: _____
(Last, then First)

PARENT / GUARDIAN: Date of Birth _____ M ☐ F ☐ Social Security #_____

Mailing Address _____City _____ State _____Zip Code _____

Cell Phone # _____ _____ Email address_____

Employer _____Job Position / Title _____ Work Phone # _____

OTHER PARENT/GUARDIAN:

PARENT / GUARDIAN NAME _____ RELATIONSHIP TO PATIENT: _____
(Last, then First)

PARENT / GUARDIAN: Date of Birth _____ M ☐ F ☐ Social Security #_____

Mailing Address _____City _____ State _____Zip Code _____

Cell Phone # _____ _____ Email address_____

Employer _____Job Position / Title _____ Work Phone # _____

In case of emergency notify:
Name: _____ Relationship_____Contact Phone # _____

INSURANCE & BILLING INFORMATION

PLEASE COMPLETE INFORMATION FOR EACH INSURANCE COMPANY

Insurance Company	Primary Insurance	Secondary Insurance	Tertiary Insurance
Insurance Address			
Policy Or Group No.			
Family Members that are Covered			
Policy Holder's Name			
Policy Holder's Date of Birth			
Policy Holder's Soc. Sec. No.			
Relationship to Patient			

AUTHORIZATION: I understand full payment for treatment received is my responsibility regardless of my insurance coverage. I hereby authorize Talkabout Inc. to release to my insurance company any information acquired in the course of examination or treatment. I further authorize my insurance company to pay directly to Talkabout Inc. any benefits due to me for services that have not been paid in full.
This authorization shall expire upon written notice or one year after services have ceased.

_____
SIGNATURE DATE

_____
NAME OF PEDIATRICIAN: UPDATE

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OCCUPATIONAL THERAPY EVALUATION QUESTIONNAIRE

FAMILY INFORMATION

Childs Name: _____ Date: _____

Birth Date: _____ Age: _____

Mother/Guardian's Name: _____

Occupation: _____

Father/Guardian's Name: _____

Occupation: _____

Living Situation: (circle one) Married Single Divorced/Separated Other

Please list ages and relationships of persons living in the home with the child:

Siblings: _____ Age: _____ Grade: _____

_____ Age: _____ Grade: _____

_____ Age: _____ Grade: _____

Others: _____

REFERRING INFORMATION

Who referred your child for an evaluation? _____

Current concerns/reason for referral: _____

_____

When was the concern first noticed? By whom? _____

_____

Has the concern/problem changed since it was first noticed? _____

_____

Is your child aware of the problem? If yes, how does he or she feel about it? _____

_____

_____

What do you see as your child's strengths? _____

_____

How is your child doing academically (or pre-academically)? _____

_____

Does your child receive special services in school? If yes, please describe: _____

_____

Hand preference: _____

Cutting out simple shapes: _____

Activities your child enjoys: _____

_____

Does your child prefer to do these activities alone or with other children/siblings? _____

Does your child socialize with extended family and close friends? _____

Does your child communicate needs, wants, and interests effectively? _____

Does your child find it hard to make friends among age-related peers? _____

Does your child prefer to stay home rather than going with the group? _____

Does your child seek out friends and companions? _____

Does your child demonstrate appropriate frustration tolerance for their age? _____

While at Play does your child: _____

- Tend to play with other younger children? _____
- Enjoy playing with toys that are age-appropriate? _____
- Enjoy time alone/playing by themselves rather then with others? _____
- Demonstrate appropriate safety-awareness for their age? _____

Is your child comfortable/behaved: _____

- Running errands or going shopping with you? _____
- Eating in restaurants? _____
- Attending birthday parties, family gatherings? _____

DEVELOPMENTAL MILESTONES

Please list the age that your child did the following, if not yet mastered place an 'X'.

Roll	_____	Sit	_____	Belly crawl	_____	Crawl on hands/knees	_____	Walk	_____
Run	_____	Skip	_____	Say first word	_____	Finger feed	_____	Use spoon	_____
Drink from cup	_____	Dress independently	_____	Use toilet independently	_____				

Do you feel that your child met his/her developmental milestones on time when compared to peers or siblings?

_____

Does your child appear to participate in age-appropriate movement activities (i.e. riding a bike, skipping, etc.)?

_____

INTERVENTION HISTORY

Please check any of the following with whom you have contacted or been seen by concerning your child. Include providers name/clinic.

[ ] Occupational Therapist
[ ] Physical Therapist
[ ] Speech and Language Pathologist
[ ] Developmental Pediatrician
[ ] Developmental Optometrist
[ ] Behaviorist
[ ] Orthopedist
[ ] Psychologist
[ ] Counseling
[ ] Others (please specify): _____

_____

_____

_____

Do other family members have any speech, motor, cognitive, or other disorders/delays? If yes, please describe:

_____

_____

_____

MEDICAL HISTORY

The following questions are posed to help in compiling a more complete picture of your child from conception and early infancy to present developmental stages. Please answer the following questions as best you can. If there is not adequate space for your comments, please continue to write on the back of this form. Thank you very much for taking the time to complete this history. It will help us greatly!

MOTHER'S PREGNANCY AND CHILD'S BIRTH:

Please check *Yes* or *No* to the following questions and remark in the space provided.

Any infections/illnesses during pregnancy? No [ ] Yes [ ] : _____

Where any drugs or medications taken during pregnancy? _____

Length of pregnancy (weeks): _____

Premature delivery? No [ ] Yes [ ]

Any difficulties during labor/delivery? (C-section, breech, sideways, cord around neck, forceps used, etc)

No [ ] Yes [ ] : _____

_____

Was medication given during delivery? No [ ] Yes [ ] : _____

_____

Were there any other complication during the pregnancy? No [ ] Yes [ ] : _____

_____

Child's weight at birth?: _____

Were there any complications? (Seizure, jaundice, congenital defects, etc) No [ ] Yes [ ] _____

_____

Was there a need for: Oxygen [ ] Transfusions [ ] Tube Feeding [ ] Other [ ] _____

_____

Length of infant's hospital stay? _____

Was the child breast-fed or bottle-fed? How long?

Were there any feeding difficulties in infancy? No [ ] Yes [ ]

Please state any other difficulties or special cares: _____

_____

Who is your Child's Physician? _____

Does your child have a diagnosis? _____

Diagnosed by whom? _____ Date: _____

History of surgeries: _____

_____

_____

History of hospitalizations: _____

_____

_____

History of ear infections: No [ ] Yes [ ] If yes, how many: _____

When was your child's most recent hearing exam? _____ Results: _____

Most recent eye exam? _____ Results: _____

Current health: _____

Date of last physical exam: _____ Results: _____

_____

Does your child have/had any other significant health issues? _____

_____

My child currently sleeps/naps: Inconsistently [ ] Well [ ] Restless [ ] Other: [ ]

My child currently eats/drinks (circle 2): At regular / irregular intervals Consistent / inconsistent amounts

Describe your child's current demeanor/behavior: _____

_____

Current Medications/Dosage/Frequency: _____

_____

Known Allergies: _____

Diet Restrictions: _____

Are immunizations up to date: No [ ] Yes [ ]

SOCIAL/EDUCATION HISTORY

School/Day Care: _____ Grade: _____

Teacher's Name: _____

Have any grades been repeated? _____

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)? If yes, describe: _____

Is your child a picky eater? If so, what texture/temperature preferences have you observed? What is your child's typical diet? _____

Describe child's response to sound (e.g. responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, distracted by sounds, sensitive to sound, etc.)? _____

Does your child resist having his/her teeth brushed? Face washed? Hair brushed? Hair cut? _____

SELF HELP SKILLS

Check applicable box (Independent, Some Help, Lots of Help, Dependent) for each skill.

		Independent	Some Help	Lots of Help	Dependent
Toileting:	Bowel				
	Bladder				
Grooming:	Bathing				
	Brushing teeth				
	Combing hair				
Dressing:	T-Shirt				
	Pants				
	Socks				
	Shoes				
Dresses in a timely manner?		Yes [ ]	No [ ]	Sometimes [ ]	
Clothing Fasteners:	Buttons				
	Snaps				
	Zipper				
	Tying shoes				
Cut out simple shapes:					
Writing name:					
Copy simple sentence:					
Feeding:	Drinks from cup				
	Drinks from straw				
	Finger feeds				
	Uses a spoon				
	Uses fork				
	Uses fork & spoon together				
	Chews & swallows well				

Are there any cultural or religious beliefs that you would like us to be aware of and/or take into consideration when we are working with your child? _____

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AUTHORIZATION FOR:

RELEASE OF INFORMATION
CONSENT FOR ELECTRONIC COMMUNICATION

Date: _____ **Child's Name:** _____

Date of Birth: _____

I am the Parent/Legal Guardian of _____ **and as such, I authorize the release of confidential information between Talkabout Inc. and each of the following that I have *initialed* next to:**

_____ **Fairbanks North Star Borough School District**
_____ **Tanana Valley Clinic**
_____ **Fairbanks Clinic**
_____ **Tanana Chiefs Conference**
_____ **Chief Andrew Isaac Health Center**
_____ **Bassett Army Hospital**
_____ **Eielson Air Force Base Clinic**
_____ **Health Net Federal Services**
_____ **Fairbanks Resource Agency (FRA)**
_____ **OTHER:** _____

_____ **Homeschool Program:** _____
_____ **Ak Center for Children & Adults (ACCA)**
_____ **Chena Health Center**
_____ **Orion Behavioral Health**
_____ **Village Health Clinic:** _____
_____ **Fireweed Pediatrics**
_____ **Providence Hospital (Anchorage)**
_____ **FACES Team**
_____ **Office of Child Services (OCS)**

_____

Please INITIAL below, indicating your consent to receive SMS text/emails:

_____ **I consent to communication via SMS text/email.**

_____ **I understand that it may contain Protected Health Information and that SMS text/email is NOT a secure means of communication.**

_____ **I understand that Talkabout Inc. is not responsible for any charges incurred via SMS text/email Communication.**

I understand that if I am <u>not</u> the biological parent of the above named child, I have submitted the appropriate legal documents to Talkabout Inc. to show legal guardianship.

I understand that information will be treated in a confidential manner. I also understand that is my right to request a copy of all information and contest any information that I feel is incorrect.

I understand that this form will remain in effect until it is revoked in writing.

Parent/Legal Guardian signature: _____ **Date:** _____

Email: _____ **Cell phone:** _____

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ATTENDANCE POLICY

In order for therapy to be successful, clients must attend on a consistent basis. Insurance companies also require that your child prove progress in their sessions, or they will not pay for services. Therefore, we have the following Attendance Policy in place:

After 3 consecutive cancellations, regardless if you have called in ahead of time to cancel, you will be removed from the clinician's schedule and placed back on the waiting list.

Even if you are calling in, you may be removed from the clinician's schedule and placed back onto Talkabout's waiting list if any of the following occurs:

- If your child's attendance rate falls below 80%
- If your child incurs 3 or more No-Call/No-Shows over the course of a 2 month period
  This includes:
  - Failing to attend a scheduled session without prior notification of absence
  - Cancelling an appointment less than 1 hour prior to start of session
  - Arriving 20 or more minutes late for a session

This attendance policy will be enforced for both regularly scheduled and rescheduled/make-up sessions. Please note, families will not be penalized for any cancellations made by the therapist.

Your child's progress, your family's time, as well as our therapists' time are important to us. Your therapist will inform you if your attendance drops below expectations. We do understand that unexpected complications occur in life and we will try our best to accommodate accordingly as we want your child to be successful both in and outside of therapy.

PARENTAL ATTENDANCE DURING THERAPY:

It is not the policy of Talkabout Inc. to include parents in the therapy session. Your clinician will be glad to share with you daily notes, daily lessons and homework at the end of the session.

I understand Talkabout Inc.'s attendance policy, as well as the parental attendance during therapy policy.

SIGNATURE Date

TalkAbout inc.

Speech and Language Therapy
Occupational Therapy

over →

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Client's Financial Policy and Agreement

Your insurance policy is a contract between you (client) and your insurance company. As a courtesy to you, we will bill your insurance for the services provided. However:

- **Insurance companies often set reimbursement schedules that are lower than customary charges. The client may still be obligated for the full amount of our charges.**
- **The client may receive service(s) in which no benefit is offered by the client's insurance company. The client will still be responsible for these charges.**
- **It is the client's responsibility to ensure that the client's insurance and/or Medicaid is current. Charges will be the client's responsibility in the event that we cannot obtain payment from your insurance company.**
- **As a courtesy, Talkabout Inc. will attempt to request authorizations for Tricare clients. However, it is the Tricare client's responsibility to ensure that an authorization is in place covering each date of service, or the client will be responsible for the full amount of our charges.**
- **If an insurance company pays the client's claim, and subsequently requests the money back because they paid in error, it is still the CLIENT'S responsibility to pay these claims IN FULL. This is REGARDLESS of the reason why the insurance company recouped the money, and REGARDLESS of the amount of time that has lapsed between the date of service and the date of the recoupment request. Unfortunately, insurance companies are not bound by any time frame for recoupment.**
- **TALKABOUT INC. reserves the right to change fees without notification.**

Client's Payment Plan Agreement

- **If a remainder is owed after the client's insurance has addressed the claim, the client is responsible for the remainder. These remainders will be paid to Talkabout Inc. on a consistent, monthly basis, according to the terms below:**
  - ***When*? the first business week of the month**
  - ***How much*? Minimum 50% of the amount of your estimated monthly remainders, but you are welcome to pay more!**
    <u>For example:</u> If your remainder is $30 per session and your child is seen twice per week, your monthly remainder total would be $240.00 ($30 x 2x/week x 4 weeks per month). Since 50% of $240.00 is $120.00, your minimum monthly payment would be $120.00.
  - **If you have a large deductible, a minimum of $300.00 per month will be paid until your deductible has been met.**
- **These remainders will be paid at the front desk, prior to your child's first monthly appointment.**
- **If payment is not received within 30 days of the first monthly appointment, services will be suspended until payment has been received.**
- **PLEASE DISCUSS EXTENUATING CIRCUMSTANCES THAT WOULD PREVENT YOU FROM PAYING WITH THE OFFICE ADMINISTRATOR.**

I have read and understand Talkabout Inc.'s Client's Financial Policy. The signature below indicates that the client waives their right to be held harmless and agrees to assume <u>all</u> financial obligations for all services rendered, including any and all claims that may be denied by the client's insurance company for any reason. These include 1) uncovered benefits or 2) services that were determined by the insurance company as not medically necessary to receive assessment or treatment, or 3) any other denial reason. I agree that I, as the client or the client's parent/legal guardian, am ultimately responsible for all charges.

Signature of Person Completing Form	Printed Name of Person Completing Form	Date

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As a courtesy to you, Talkabout Inc. will bill your insurance company for services rendered. Since your insurance company will not fully communicate your family's benefits with us, we ask that you contact them directly to gather the information below. Once completed, it will give you an idea of your approximate out of pocket costs (ie: deductible and copay) for services at Talkabout Inc. Errors or incomplete information may result in unexpected charges or large out of pocket costs, which we'd all like to avoid.

If your insurance changes at any time, this form would need to be completed again, as your benefits would most likely change with any new insurance coverage.

QUESTIONS TO ASK YOUR INSURANCE

CHILD'S NAME _____ **CHILD'S Date of Birth** _____

NAME OF PRIMARY INSURANCE COMPANY: _____

EFFECTIVE DATE COVERAGE BEGAN: _____

SECONDARY INSURANCE COMPANY:

EFFECTIVE DATE COVERAGE BEGAN: _____

Is there a benefit for Speech Therapy / Occupational Therapy? Yes ☐ No ☐
Please let them know that your child's therapy is NOT considered "restorative" therapy.

Is there a maximum number of visits allowed? Yes ☐ No ☐
If so, how many are allowed? _____ per _____ Is there a lifetime cap? Yes ☐ No ☐

Is pre-authorization required? Yes ☐ No ☐ If so, this is something that you would need to obtain, initially.

Is your policy a calendar year (January 1 renewal), or a fiscal year (July 1 renewal), policy? _____

How much is your annual deductible? _____
How much is remaining before you meet your deductible for this year? _____

How much will your copay, per visit, be? _____

PLEASE NOTE:

- If a remainder is owed after your insurance has addressed the claim, you are responsible for the remainder.
- These remainders shall be paid monthly at the front desk, over the phone or via our website (talkaboutinc.com).
- If payment is not received within 30 days of the first monthly appointment, services may be suspended until payment has been received.
- PLEASE DISCUSS WITH THE OFFICE ADMINISTRATOR ANY EXTENUATING CIRCUMSTANCES THAT WOULD PREVENT YOU FROM PAYING.
- Please understand that therapists are only paid if they perform therapy with a client.
- If your child is not able to attend their appointment, please let us know as soon as possible. This courtesy helps the therapist arrange their schedule accordingly. We understand that life happens and will extend the same courtesy to you if we need to cancel your child's appointment.

Signature of Person Completing Form **Printed Name of Person Completing Form** **Date:**

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Informed Consent for Teletherapy

CONSENT FOR TELEHEALTH CONSULTATION **CHILD'S NAME:** _____

1. I understand that my child's speech- language pathologist and/or occupational therapist wishes my child to engage in a telehealth consultation.
2. I understand and consent to my child's Personal Health Information (PHI) being discussed through unencrypted email in order to initially set up telehealth service.
3. My child's speech-language pathologist and/or occupational therapist explained to me how the video conferencing technology that will be used to affect such a consultation will work during therapy sessions.
4. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my child's health-care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
6. I have had a **direct conversation** with my child's provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY TALKABOUT, INC.

Doxy.me is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. There is a simple link to follow by email. By signing this document, I acknowledge:

1. Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my child's provider and I may be in direct, virtual contact through the Telehealth Service, Doxy.me, does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Doxy.me Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my child's provider has access to any or all of the technical information in the Doxy.me Service – or that such information is current, accurate or up-to-date. I will not rely on my child's health care provider to have any of this information in the Doxy.me Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Printed Name Date

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Consent for Observation

_____, the parent or guardian of
(Name of parent or guardian)

_____, authorize Talkabout Inc.
(Name of child)

to allow a college student to observe the above named child during speech and / or occupational therapy for educational purposes.

This consent shall remain in effect for the duration of therapy sessions with Talkabout Inc., or until revoked in writing below.

_____ _____
Signature of parent or guardian Date

_____ _____
Date revoked Signature of parent or guardian

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NOTICE OF PRIVACY PRACTICES

EFFECTIVE SEPTEMBER 20, 2013
UPDATED MAY 1, 2017

This notice describes how medical information about you may be used and disclosed, as well as how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

This Notice describes the medical information practices of Talkabout Inc. Talkabout Inc. is considered a covered entity, and therefore we are required by law to maintain the privacy of personal health information and to provide you with notice of our legal duties and privacy practices with respect to personal health information. All Talkabout Inc. departments or programs are covered by this Notice and your personal health information may be shared among these divisions.

Our Pledge Regarding Medical Information

We understand that medical information about your health is personal. We will not disclose your personal health information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. This Notice applies to all of the medical records we maintain. It describes the ways in which we may use and disclose medical information, and describes our obligations with regard to such information. .

We are required by law to:
- Keep your protected health information private;
- Provide notice of our legal duties and privacy practices with respect to protected health information;
- Notify affected individuals following a breach of unsecured protected health information;
- Give you this Notice of Privacy Practices; and
- Follow the terms of the Notice of Privacy Practices currently in effect.

We have the right to change our practices regarding the personal health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling the Privacy Officer, David Jamison, at 907-452-4517, or by stopping by the Privacy Officer's office at 1327 Kalakaket St., Fairbanks, AK 99709.

How We May Use/Disclose Your Medical Information

The following are some of the different ways that we may use and disclose your personal health information:

For Treatment. We may use or disclose medical information about you to facilitate treatment, rehabilitation or treatment through services provided by Talkabout Inc. For example, we may disclose medical information to other healthcare providers who are involved in taking care of you.

For Payment. We may use and disclose medical information about you to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies (either directly or through a third party billing company), medical necessity determinations and reviews, and collection of outstanding accounts.

For Health Care Operations. We may use and disclose medical information about you for other Talkabout Inc. health care operations necessary to run Talkabout Inc. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; licensing; personnel training programs; fraud and abuse detection programs; and general Talkabout Inc. administrative activities.

To Business Associates. There are some services provided to Talkabout Inc. through contracts with business associates. Examples include accounting, legal, training, and consulting services. Information shall be made available to business associates consistent with their need to know for purposes of providing services.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Other Uses and Disclosures

We may also use and disclose your health information in the following circumstances, when permitted by law, and with only the minimum necessary information being disclosed:

- Appointment reminders
- Language interpreters
- Information about available treatments or products
- Funeral Directors/Coroners/State Medical Examiners
- Workers' Compensation
- Correctional Institutions (if you are in jail or prison)
- Law Enforcement
- Tissue and organ donation
- Disaster relief
- Military and Veterans (if you are an armed forces member)
- Responses to legally compliant court orders
- National security

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. This includes the use or disclosure of psychotherapy notes, the use or disclosure of PHI for marketing, or the sale of PHI, which will require your express written authorization.

Your Rights Regarding Personal Health Information

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to, or copies of, this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. If your records are held in electronic format, you may also obtain an electronic copy if it is reasonably available. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must provide a supporting reason, be made in writing, and be submitted to the Privacy Officer. If we agree to amend the information, we will generally amend your information within 60 days of your request and will notify you when we have amended the information

We may deny your request for an amendment if does not meet the requirements listed above. In addition, we may deny your request if you ask us to amend information that: is not kept by or for Talkabout Inc.; was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request a list of disclosures, where such disclosure was made for any purpose other than treatment, payment or health care operations. We are not required to give you an

accounting of information we have shared with our business associates or for which you have given us a written authorization.

To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years or before April 14, 2003. Your request should indicate in what form you want the list (i.e. paper or electronic). The first list you request within a 12-month period will be free, and you may be charged for the cost of any additional lists. We will notify you of the cost and you may choose to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a transport or treatment we provided. We are not required to agree to your request unless the disclosure is to a health plan for purposes of carrying out payment or health care operations (not treatment purposes) and the information pertains solely to an item or service paid for fully out of pocket.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must describe: (1) what information you want to limit; (2) whether you want to limit use, disclosure or both; and (3) to whom the limits shall apply, for example, your spouse.

Right to Request Confidential Communications. You can request that we communicate confidentially with you about medical matters. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will accommodate reasonable requests. Your request must specify how you wish to be contacted.

Right to a Paper Copy of This Notice. You may request a paper copy at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy.

Right to Revoke Authorization/Permissions
If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. Your substance abuse records received by a person or entity pursuant to your written authorization may not be re-disclosed without your written consent.

Questions/Exercising Rights

If you have any questions about this Notice or would like to exercise any of the rights contained herein, please contact: Talkabout Inc. Privacy Officer, David Jamison, 1327 Kalakaket St., Fairbanks, AK 99709.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Talkabout Inc. or with the Secretary of the Department of Health and Human Services. To file a complaint with Talkabout Inc., contact the Privacy Officer. All complaints must be submitted in writing. You will not be retaliated against or penalized for filing a complaint.

The Secretary of DHHS can be reached at: Office for Civil Rights; U.S. Department of Health and Human Services; 200 Independence Avenue. S.W.; Room 509F, HHH Building; Washington, D.C. 20201.

I have read the Notice of Privacy Practices and understand my rights according to HIPAA.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Client's Name Signature & Date of Staff receipt

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. PATIENT STATUS Single Married Other	CITY STATE
ZIP CODE TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ____ 2. ____ 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

PLEASE PRINT OR TYPE

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500,