



## 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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### CASE HISTORY QUESTIONNAIRE

**Please fill out all areas:**

**Date:**                     

Name of Child: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Does the child live with both parents? \_\_\_\_\_ Yes \_\_\_\_\_ No

Mother's Name \_\_\_\_\_ Mother's Occupation \_\_\_\_\_

Father's Name \_\_\_\_\_ Father's Occupation \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Clinic: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_

Brothers and Sisters (include names and ages):  
\_\_\_\_\_  
\_\_\_\_\_

### **SIGNIFICANT HISTORY:**

What is the problem/concern? \_\_\_\_\_  
\_\_\_\_\_

When was it first noticed? \_\_\_\_\_  
\_\_\_\_\_

What has been done about it? \_\_\_\_\_  
\_\_\_\_\_

Is it worse at some times than others? \_\_\_\_\_  
\_\_\_\_\_

### **Speech:**

Does your child seem to have trouble understanding speech? \_\_\_\_\_ YES \_\_\_\_\_ NO

Does your child seem to enjoy listening to stories? \_\_\_\_\_ YES \_\_\_\_\_ NO

Can both parents understand your child's speech? \_\_\_\_\_ YES \_\_\_\_\_ NO

How does your child react when the following do not understand him/her?

Relative \_\_\_\_\_

Teacher \_\_\_\_\_

Playmates \_\_\_\_\_

Does your child talk \_\_\_\_\_ Frequently \_\_\_\_\_ Seldom \_\_\_\_\_ Never

Is speech used meaningfully? \_\_\_\_\_ YES \_\_\_\_\_ NO

Which speech sounds does your child prefer to use? \_\_\_\_\_ Complete sentences \_\_\_\_\_ Phrases  
\_\_\_\_\_ Words \_\_\_\_\_ Sounds

Is his/her speech accompanied by any unpleasant movements or facial expressions? \_\_\_\_\_ YES \_\_\_\_\_ NO

Is the pitch of his/her voice \_\_\_\_\_ Too high \_\_\_\_\_ Too low \_\_\_\_\_ Too Soft \_\_\_\_\_ Too Loud

Is the child's voice hoarse? \_\_\_\_\_ YES \_\_\_\_\_ NO

Are there any other languages besides English spoken at home? \_\_\_\_\_ YES \_\_\_\_\_ NO

If so, which language is it? \_\_\_\_\_

Does any other family member have speech difficulties? \_\_\_\_\_ YES \_\_\_\_\_ NO

Is YES, please explain \_\_\_\_\_

What questions are you hoping to have answered as a result of this evaluation? \_\_\_\_\_

### **Speech/Language Milestones**

During the first 5 months, other than crying, would you say your infant was:

A Silent Baby \_\_\_\_\_ An Average Baby \_\_\_\_\_ A Noisy Baby \_\_\_\_\_

Did your infant respond to noise? \_\_\_\_\_ If so, how? \_\_\_\_\_

At what age did he/she say first words? \_\_\_\_\_

Did he/she get one or two words and then go a long time before getting new words? \_\_\_\_\_ YES \_\_\_\_\_ NO

At what age did he/she use word combinations like "want cookie" or "me out"? \_\_\_\_\_

At what age did he/she use more short, complete sentences? \_\_\_\_\_

Did speech learning ever stop for a period? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

What efforts have been made to help your child talk better? \_\_\_\_\_

Has there been a change in your child's speech within the last 6 months? \_\_\_\_\_ YES \_\_\_\_\_ NO

Better than 6 months ago? \_\_\_\_\_ YES \_\_\_\_\_ NO Worse than 6 months ago? \_\_\_\_\_ YES \_\_\_\_\_ NO

Does your child need to be urged to speak? \_\_\_\_\_ YES \_\_\_\_\_ NO

### **Behavior**

Does your child sleep well? \_\_\_\_\_ YES \_\_\_\_\_ NO

Does your child tend to play by himself/herself or with other children? \_\_\_\_\_

Are playmates the same age as your child? \_\_\_\_\_ YES \_\_\_\_\_ NO

Does your child have difficulty concentrating? \_\_\_\_\_ YES \_\_\_\_\_ NO

Is discipline difficult at home? \_\_\_\_\_ YES \_\_\_\_\_ NO

Check the traits that describe your child:

\_\_\_\_\_ Easily makes friends \_\_\_\_\_ Withdrawn \_\_\_\_\_ Temper Tantrums

\_\_\_\_\_ Uncooperative \_\_\_\_\_ Cooperative \_\_\_\_\_ Happy

## **MEDICAL HISTORY:**

**Is your child on any medications? If yes, identify:** \_\_\_\_\_

**Does your child have any allergies? \_\_\_\_\_ If yes, identify:**

### **Birth History**

Did the mother have any accidents, illnesses (German Measles, RH incompatibility, false labor) or other unusual complications during pregnancy? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, please explain \_\_\_\_\_

Age of mother at child's birth \_\_\_\_\_ Length of Pregnancy? \_\_\_\_\_

Birth weight of child \_\_\_\_\_

Were medications used during labor or delivery? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, please explain \_\_\_\_\_

Was your baby incubated? \_\_\_\_\_ If yes, how long? \_\_\_\_\_

Did you infant have trouble starting to breathe? \_\_\_\_\_ YES \_\_\_\_\_ No

Was your infant blue? \_\_\_\_\_ YES \_\_\_\_\_ NO

Was your infant given oxygen? \_\_\_\_\_ YES \_\_\_\_\_ NO

Was your infant jaundice? \_\_\_\_\_ YES \_\_\_\_\_ NO

Check the illnesses which your child has had and the child's age at the time of the illnesses:

Illness	Age	Mild	Mod.	Sev.	Illness	Age	Mild	Mod.	Sev.
Adenoidectomy					Heart Problems				
Allergies					High Fevers				
Asthma					Influenza				
Blood Disease					Mastoidectomy				
Cataracts					Measles				
Chickenpox					Meningitis				
Chronic Colds					Mumps				
Convulsions					Muscle Disorder				
Cross-eyed					Nerve Disorder				
Croup					Orthodontia				
Dental Problems					Pneumonia				
Diphtheria					Polio				
Earaches					Rheumatic Fever				
Ear Infections					Scarlet Fever				
Encephalitis					Tonsillectomy				
Headaches					Tonsillitis				
Head Injuries					Whooping Cough				

Illnesses/Age/Severity of Child at time of the Illness:

\_\_\_\_\_ Gland Trouble \_\_\_\_\_ Meningitis \_\_\_\_\_ Other \_\_\_\_\_

Were any of the illnesses listed above followed by a noticeable change in your child's behavior or his/her speech and/or hearing abilities? If yes, please explain \_\_\_\_\_

Was your child ever hospitalized? \_\_\_\_\_ For How Long? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Has your child ever had any severe accidents? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

### PREVIOUS EXAMINATIONS AND TREATMENTS

Please specify: When \_\_\_\_\_ Where \_\_\_\_\_ and By Whom \_\_\_\_\_

Speech Evaluation \_\_\_\_\_

Speech Therapy \_\_\_\_\_

Hearing Evaluation \_\_\_\_\_

Ear, nose and throat \_\_\_\_\_

Medical \_\_\_\_\_

Dental \_\_\_\_\_

Neurological \_\_\_\_\_

Psychological \_\_\_\_\_

**Feeding History**

Does your child eat well? \_\_\_\_\_ YES \_\_\_\_\_ NO

What are his/her favorite snacks? \_\_\_\_\_

Did your infant have any of the following: \_\_\_\_\_ Seizures \_\_\_\_\_ Sores or Bruises  
\_\_\_\_\_ Feeding problems \_\_\_\_\_ Swallowing Difficulties \_\_\_\_\_ Cleft lip or Palate

Was birth weight regained quickly? \_\_\_\_\_ YES \_\_\_\_\_ NO

Does your child have any restricted foods? \_\_\_\_\_ If yes, Describe \_\_\_\_\_

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**Educational History:**

School: \_\_\_\_\_ Grade: \_\_\_\_\_

How is the child doing academically (or pre-academically)?

\_\_\_\_\_ Above average

\_\_\_\_\_ Average

\_\_\_\_\_ Below Average

Does your child receive special services? If yes, describe:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Person Completing Form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Person Completing Form

\_\_\_\_\_  
Relationship to 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

\_\_\_\_\_ Homeschool Program: \_\_\_\_\_

\_\_\_\_\_ Tanana Valley Clinic

\_\_\_\_\_ Ak Center for Children & Adults (ACCA)

\_\_\_\_\_ Fairbanks Clinic

\_\_\_\_\_ Chena Health Center

\_\_\_\_\_ Tanana Chiefs Conference

\_\_\_\_\_ Orion Behavioral Health

\_\_\_\_\_ Chief Andrew Isaac Health Center

\_\_\_\_\_ Village Health Clinic: \_\_\_\_\_

\_\_\_\_\_ Bassett Army Hospital

\_\_\_\_\_ Fireweed Pediatrics

\_\_\_\_\_ Eielson Air Force Base Clinic

\_\_\_\_\_ Providence Hospital (Anchorage)

\_\_\_\_\_ Health Net Federal Services

\_\_\_\_\_ FACES Team

\_\_\_\_\_ Fairbanks Resource Agency (FRA)

\_\_\_\_\_ Office of Child Services (OCS)

\_\_\_\_\_ OTHER: \_\_\_\_\_

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 not 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





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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!  
**For example:** If your remainder is \$30 per session and your child is seen twice per week, your monthly remainder total would be \$240.00 ( $\$30 \times 2x/\text{week} \times 4 \text{ weeks per month}$ ). 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 all 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 it 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.

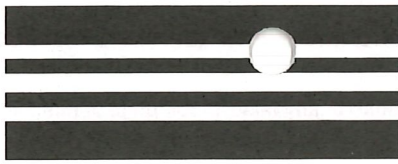
\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Client's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature & Date of Staff receipt

PLEASE DO NOT STAPLE IN THIS AREA



HEALTH INSURANCE CLAIM FORM

Form with multiple sections: 1. MEDICARE/MEDICAID/CHAMPUS/CHAMPVA/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PHYSICIAN; 17a. I.D. NUMBER OF REFERRING PHYSICIAN; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION CODE; 23. PRIOR AUTHORIZATION NUMBER; 24. TABLE with columns A-K; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. NAME AND ADDRESS OF FACILITY; 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PLEASE PRINT OR TYPE