

GREATER ATLANTA SPEECH AND LANGUAGE CLINICS, INC.

3465 Lawrenceville Suwanee Rd,
Suite A, Office C
Suwanee, GA 30024

1000 Johnson Ferry Road
Suite A100
Marietta, Georgia 30068
(770) 977-9457
Fax (770) 977-5087

For Clinic Use: Therapist Name: _____ Clinic: _____ Payment Method: _____

PATIENT INFORMATION

Please complete the following information for all patients (please print legibly):

Patient Name: _____
(Last • First • Middle)

Address: _____

City State Zip

Sex: M F Age: _____ Date of Birth: ____/____/____

Patient SS#: _____

If patient is a child, please complete the following:

Names of Parents/Guardians of above named patient:

Marital Status of Parents: Single Married Widowed Separated Divorced

Mother's Employer & Address: _____

Father's Employer & Address: _____

Adult patients, please complete the following:

Employer: _____

Employer Address: _____

Name of Spouse (if applicable): _____

Spouse's Employer: _____

CONTACT NAMES & PHONE NUMBERS

Home #: _____

Work # (Mom/Dad/Self): _____

Cell # (Mom/Dad/Self): _____

to call to cancel/change appts: _____

Emergency Contact Name/Phone #: _____

E-mail address: _____

Patient's Physician's Name & Address: _____

Physician's Phone #: _____

FINANCIAL RESPONSIBILITY INFORMATION:

Who is the responsible party for this account? _____

Relationship to Patient: _____

Date of Birth of Responsible Party: _____

SS# of Responsible Party: _____

INSURANCE/MEDICAID INFORMATION

If patient is covered by insurance complete the following information:

Insurance Company: _____

ID & Group #: _____

Primary Insured/Subscriber Name: _____

Relationship to Patient: _____

Date of birth of primary insured: _____

SS# of primary insured: _____

If patient is covered by Medicaid complete the following information:

Medicaid #: _____

Type of Medicaid coverage:

____ Peachcare ____ Deeming Waiver ____ GA Medicaid

If Peachcare/GA Medicaid, who is provider:

____ Wellcare ____ Peachstate ____ Amerigroup

ASSIGNMENT AND RELEASE

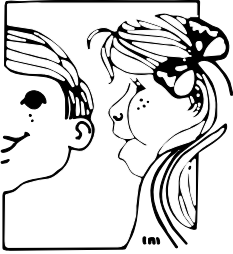
I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Greater Atlanta Speech and Language Clinics, Inc.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Greater Atlanta Speech and Language Clinics, Inc.** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____

Relationship to patient _____ Date _____

Whom may we thank for referring you: _____

Thank you for trusting us with your therapy needs. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call.



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FINANCIAL POLICY

Thank you for choosing Greater Atlanta Speech and Language Clinics, Inc., to provide your speech and/or occupational or physical therapy. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

All patients must complete and submit all of the forms in our "Patient Information" packet before seeing the therapist.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT PAYMENTS BY CASH, CHECKS, AND MOST MAJOR CREDIT CARDS.

All patients are responsible for full payment at time of service. GASLC, Inc., regards the adult party who signs below as "Parent or Responsible Party" to be the responsible guarantor for that patient's account in all cases and without exception.

We may accept assignment of insurance benefits after we receive all necessary insurance information (as requested on the Patient Information form) along with a copy of your insurance card. The co-pay listed on your card is expected at each visit. Please be aware that some and perhaps all of the services provided may be "non-covered" services with your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event your insurance company denies coverage, ***you will be responsible for payment of all charges*** and we require that you pay the balance of the account on the first of every month. If your plan requires a referral or preauthorization for special services, it is your responsibility to obtain the referral and insure that the preauthorization is approved prior to beginning services. Most doctors will not issue referrals after the fact. You will be responsible for any charges refused by your insurance company because the necessary referrals or preauthorization were not obtained.

UCR (Usual and Customary Rates)

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

We require 24 hours advance notification in order not to charge for missed appointments. We will make an exception in the case of sudden illness or injury or other family emergency if the appointment is cancelled prior to 8:00 a.m. the day of the appointment. Please help us serve you better by keeping scheduled appointments. Due to our growing waiting list, if three sessions are missed without prior cancellation, we may find it necessary to discontinue services. You will be placed on a waiting list and therapy will resume when and if another space becomes available in a therapists' schedule.

Past Due Accounts

GASLC, Inc. will exercise the right to charge 1.5% interest on past due accounts. This will accrue each 30 days the account is over due.

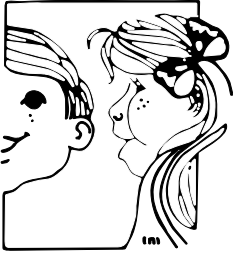
Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the above Financial Policy and understand and agree to abide by this Policy.

Signature of Parent and/or Responsible Party

Name of Client (Print)

Relationship to Client

Date



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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

The undersigned authorizes Greater Atlanta Speech and Language Clinics, Inc., to release pertinent information (initial evaluation report, progress reports, clinical notes) to:

Physician/School/Facility Name

Physician/School/Facility Name

Address

Address

Address

Address

Phone/Fax

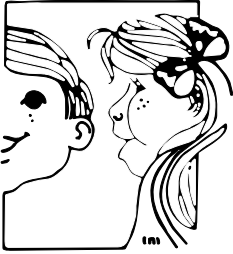
Phone/Fax

when such information is necessary in the therapeutic program of the patient.

Patient Name (Print)

Parent/Guardian/Patient (Signature)

Date



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CONSENT TO RELEASE CONFIDENTIAL INFORMATION FOR INSURANCE PURPOSES

I authorize the release of any medical or other information that is necessary to process claims or approve therapy treatment to my insurance company (such as initial evaluations, progress reports, clinical notes, including evaluations from other clinics or schools):

I authorize GASLC to release the following information from other facilities to my insurance company (only as requested by the insurance company):

1. _____
2. _____
3. _____
4. _____

Name of insurance company: _____

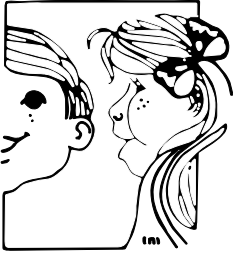
Signed: _____ Date: _____
(Parent/Guardian/Insured)

Name of patient: _____

I authorize payment of medical benefits directly to Greater Atlanta Speech and Language Clinics, Inc., for services

rendered to _____
(name of client)

Signed: _____ Date: _____
(Parent, Guardian, Insured)



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CONSENT TO REQUEST CONFIDENTIAL INFORMATION

To: _____
(Agency, school, physician, etc.)

Address: _____

Re: _____

The undersigned authorizes Greater Atlanta Speech and Language Clinics, Inc., to request the following information you have concerning the above patient:

- a. Copies of all therapy services including notes, clinical evaluations, etc.
- b. Copies of all education reports
- c. Copies of all medical and hospital reports
- d. Other: _____

Signed: _____ Date: _____
(Parent/Guardian/Client)

Witness: _____

Acknowledgment of Receipt of Privacy Practices

I, _____ have received a copy of **Greater Atlanta Speech & Language Clinics, Inc.**'s Notice of Privacy Practices with an effective date of April 14, 2003.

Name of Patient: _____

Address of Patient: _____

Signature of Patient _____ **Date** _____
(Or Parent/Guardian of Patient)

Name of Witness: _____

Signature of Witness _____ **Date** _____

Notice of Privacy Practices

April 14, 2003

Greater Atlanta Speech & Language Clinics, Inc.

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) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, 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.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include speech, occupational, or physical therapy services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical plan for your therapy services.
- **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 include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

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 certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, 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 request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

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.

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. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

The Clinical Director
Mindy C. Elkan, M.A., CCC
Greater Atlanta Speech & Language Clinics, Inc.

1000 Johnson Ferry Rd., Suite A100

Marietta, GA 30068

3465 Lawrenceville Suwanee Rd., Suite A, Office C

Suwanee, GA 30024

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)