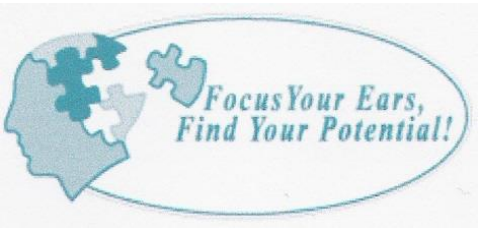


Laurie Ross Brennan & Associates

PERSONAL DATA INFORMATION SLP/AIT

DATE_____

PATIENT NAME_____
FIRST MIDDLE LAST

DATE OF BIRTH_____ MALE ☐FEMALE ☐

SOCIAL SECURITY NUMBER_____

NAME OF PARENT/GUARDIAN_____

PHYSICAL ADDRESS_____
CITY STATE ZIP

MAILING ADDRESS_____

EMAIL ADDRESS _____
CITY STATE ZIP

PHONE HOME_____CELL_____WORK_____

RESPONSIBLE PARTY_____

INSURANCE INFORMATION

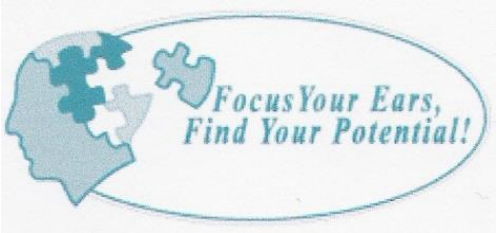
PRIMARY INSURANCE NAME_____POLICY #_____

SECONDARY INSURANCE NAME_____POLICY #_____

POLICY HOLDER NAME_____DATE OF BIRTH_____

POLICY HOLDER RELATIONSHIP TO PATIENT_____

PRIMARY CARE PHYSICIAN NAME_____PHONE #_____



RECEIPT OF LAURIE ROSS BRENNAN & ASSOCIATES PRIVACY NOTICE

I, the undersigned, acknowledge receipt of the Laurie Ross Brennan & Associates

Notes of Private Practices on _____ _____, 20____
Month Day Year

_____
Signature of Patient/Guardian/Parent

_____
Printed Name of Patient

_____
Relationship to Patient

We at LAURIE ROSS BRENNAN & ASSOCIATES are vigilant to protect patient confidentiality. No information regarding our patients is shared or distributed with any other person or organization without the patients' signed authorization. Any questions or comments may be directed to our HIPAA Coordinator at 505-268-5933

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 and 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 applies to all health care providers, it is intended to standardize health care information as well as ensure privacy and security of patient information. As a result of this Act, Laurie Ross Brennan & Associates (LRBA) would like to advise you of how we will protect the privacy of your or your child's medical record.

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.

If you sign a consent form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would be disclosure of your Protected Health Information (PHI) to providers outside LRBA such as your outside case manager, treatment team members, doctors, nurses and other health care providers in connection with your health care treatment.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be telling your health plan about a treatment you are going to receive to determine whether your plan will pay for that treatment
- Health Care Operations includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer services. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose PHI to doctors, nurses, therapists, students and other health care personnel for teaching purposes.

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

Legal Authority to make health care decisions for minors or others Usually, the health information rights described in this Notice may be given to a person with legal authority to make health care decisions for a child or other person (for example, a parent or legal guardian). There are exceptions. For example, in New Mexico some health care services can be provided to a minor without the consent of a parent, guardian or other person. In these cases, the minor has the rights described in this Notice for health information related to the health care service provided.

We may without prior consent use or disclose protected health information to carry out treatment, payment or health care operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we attempt to obtain your consent but are unable to do so due to substantial barrier to communicating with you and we determine that in our professional judgment, your consent to receive treatment is clearly inferred from circumstances.

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 our Privacy Officer or your therapist.

- The right to request restrictions on certain uses and disclosures of PHI including those related to disclosures to family members, 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 communication of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of PHI.
- The right to obtain a paper copy of this notice from us upon request.

PERMITTED USE OR DISCLOSURE WITH AN OPPORTUNITY FOR YOU TO AGREE OR OBJECT

- **Research** As a professional medically based therapeutic center, we may use and disclose PHI about you for research purposes. We will only use and disclose your information for a research project if we obtain your permission or if the need to obtain your permissio n has been waived by a designated review committee that meets Federal requirements.
- **Promotional Communications** LRBA does not share or .sell your PHI to companies that market health care products or services directly to consumers. LRBA may maintain mailing lists of individuals for promotional materials and news about LRBA or therapy ideas. These include our newsletter and other information of this nature. You may be included on these lists. LRBA may send information about its programs and services to the individuals on these lists. If you wish to be removed from the LRBA mailing lists, please send written notice to . LRBA 4811 Hardware Dr NE E-1, Albuquerque, NM 87109.
- **To Avert A Serious Threat to Health or Safety** We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of others. Disclosure will only be to persons who could help prevent the threat.
- **To Have Supervised Students Providing Care** LRBA prides itself for remaining on the cutting edge of providing therapy. One of the ways we maintain this status is by arrangements with Universities across the country that train therapists. We have students observing or doing rotations at LRBA that last from a few days to 16 weeks. These students are generally outstanding and many of them have been hired by LRBA after they complete their University Degree Program. Students are supervised by our therapists according to the requirements of their professional standards and the University Program. If you object to having a student involved in your therapy, please send wr itten notice to LRBA 4811 Hardware Dr NE E-1, Albuquerque, NM 87109.
- **To Have Your Picture Taken** We have taken pictures of clients to use in therapy sessions, use in publications to demonstrates specific therapy approaches, for training clients, family caregivers and LRBA staff, as well as for placement in the LRBA hallway of clients served. We require written permission for photographing or videotaping a client or session prior to doing so. If you· change your mind a nd decide that you no longer want LRBA to take images, please send written notice to. Ho wever, any images that LRBA had taken prior to this decision remain property of LRBA 4811 Hardware Dr NE E-1, Albuquerque, NM 87109.er and we can continue to use them.

USE OR DISCLOSURE PERMITTED BY PUBLIC POLICY OR LAW WITHOUT YOUR AUTHORIZATION

- **Military** We may disclose your PHI as required by military command authorities if you are in the armed services.
- **Workers Compensation** We may disclose your PHI for workers' compensation or similar programs to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law. These programs provide benefits for work -related injuries or illness.
- **Public Health Risks** As required by law, we may disclose your PHI for public health activities. For example, we may undertake these activities:
  - To prevent or control disease, injury or disability;
  - To report child abuse or neglect,
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition,
  - To notify the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure subject to certain requirements when mandated or authorized by law; and
  - To notify an individual that a client tells us that they are intending harm, neglect or abuse in order to protect both that person and our client.
- **Lawsuits and Disputes** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request or other lawful process.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practice with respect to PHI.

This notice was effective as of April 14, 2003 and revised January 7, 2006 and we are required to abide by the terms of the N otice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post this notice and you may request a written copy of a revised Notice of Privacy Practices from our office.

If you want more information about HIPAA or believe your privacy rights have been violated, contact one or both of the following departments:

Laurie Ross Brennan & Associates HIPAA Compliance Officer
4811 Hardware Dr. NE E-1
Albuquerque, NM 87109
505.268.5933
fax: 505.268.0184

OR

Office of Civil Rights; US Department of Health and Human Services
1301 Young Street, Suite 1169 — 200 Independence Avenue SW
Dallas, TX 75202 — Washington, DC 20201
Phone (214) 767-4056 FAX (214) 767-0432 TDD: (214) 767-8940 Toll Free: 1-877-696-6775

Please provide as much information as possible so your complaint may be properly investigated.
You will not be penalized for filing a complaint.

Patient Name:_____

Contract for Therapy Services

At Laurie Ross Brennan & Associates (LRBA), we strive to provide you with the best possible service at a fair, affordable price. We are committed to the highest ethical standards in the conduct of our therapy services and business operations, and we will demand full compliance with all federal, state and local laws. Our therapists will support you in advocating for your child by providing education, awareness, and the highest quality therapy services. In the policies below, we will refer to the person receiving therapy as "The Patient." Please read and initial each policy below.

Initials

_____ **AUTHORIZATION TO TREAT A MINOR**

I authorize the therapeutic treatment of _____, by qualified speech language therapists at Laurie Ross Brennan & Associates.

_____ **PAYMENT RESPONSIBILITY**

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I agree that if the insurance company denies payment for these claims or I do not notify Therapy when my insurance has changed or terminated prior to services, I will pay LRBA for the total allowable amount due for all treatment sessions. If there are unpaid insurance claims that need resolution, I will be notified by LRBA in a timely manner. I may also choose to contract for therapy on a private pay basis if prior authorization requests are denied.

I agree to pay the insurance co-payments, co-insurance, and/or deductible according to my insurance policy. I understand that per my insurance company guidelines co-payments are **due at time of service**.

_____ **NON-SUFFICIENT FUNDS "NSF" FEE**

LRBA will charge a $25 NSF Fee for any returned checks due to insufficient funds.

_____ **STATEMENTS**

In some instances, I may receive a monthly statement with my deductible or co-pay/co-insurance balance. This statement balance is due upon receipt. I further understand if my balance is over 60 days past due, treatment for my child will be stopped until payment arrangements have been made. If treatment is stopped, there is **no guarantee** of continuing services with the same time slot or with the same therapist. I will be notified two (2) weeks in advance before treatment is discontinued. It is my responsibility to contact LRBA's billing company regarding any questions on my statement.

_____ **FINANCE CHARGES**

LRBA will add a 10% finance charge for client balances past 90 days if no attempt has been made for resolution of payment.

_____ **DIAGNOSTIC TESTING**

The insurance company may not cover diagnostic testing and other therapeutic services. I will be notified of these charges prior to service delivery and agree to pay if the insurance company does not cover these services. See current rate sheet for details.

_____ **AIT SCREENING**

I understand that today's appointment is not a hearing test, but a screening to be used only to determine if Auditory Integration Training (AIT) would be an appropriate treatment for this client. It is not an audiological assessment and will not be used to make any audiological recommendations

Patient Name:_____

_____ **AUTHORIZATION TO PHOTOGRAPH**

Laurie Ross Brennan & Associates has my permission to photograph, film or tape record activities in which "The Patient" is participating and to use these photographs, films and tape recordings for educational programs and/or educational presentations.

_____ **AUTHORIZATION FOR STUDENT/VOLUNTEER OBSERVATION**

LRBA is a clinic that supports the development of students from across the country in speech and language therapy. To accomplish this, students are provided the opportunity for clinical observations and fieldwork experiences throughout the year. I give permission to allow students and volunteers to observe/interact with "The Patient" under the direct supervision of a licensed therapist.

_____ **AUTHORIZATION FOR DISCUSSING PATIENT'S STATUS IN THE WAITING ROOM**

Due to the high volume of client traffic at LRBA, it is common for private conversations to occur in the waiting room. I give permission for my therapist to discuss with me, my representative or caregiver the current status, issues or concerns regarding "The Patient" in the waiting room prior to and after the session. If I do not want any personal information regarding The Patient" discussed in the waiting room, I recognize that it is my responsibility to let my therapist know.

_____ **AUTHORIZATION TO USE TREATMENT DATA FOR RESEARCH PURPOSES**

By signing I am authorizing LRBA to use treatment data regarding "The Patient" for research purposes. I understand that the data used will be completely anonymous.

_____ **CONSENT OF DISCLOSURE**

I hereby give consent to LRBA to use and disclose my protected health information for the purposes of treatment, payment and health care operations. I acknowledge that I may cancel this consent at any time. Cancellation must be done in writing, signed by me, and delivered to LRBA either by mail or hand delivered. Regardless, my cancellation will not be in effect until LRBA receives the notification. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

_____ **COMPLAINT TO INSURANCE COMMISSIONER**

I authorize LRBA to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ **COMPLAINT/GRIEVANCE PROCEDURE**

If I have a complaint about any of the services, the quality of care I receive, or the choice of therapists I have as a member, I will call the Clinic Director at (505)268-5933. I will notify LRBA by letter, or by telephone when I have a complaint. The complaint will be reviewed within 30 calendar days. If I am not satisfied with the decision, I may file an appeal. If I am still not satisfied with the results of the appeal, I can file a grievance with the New Mexico State Regulation and Licensing Department according to their procedures.

_____ **SERVICE AGREEMENT**

We reserve the right to refuse service to anyone if we are unable to come to a mutual agreement regarding any specific matter.

My signature acknowledges I have read and understand all the above policies.

_____ _____

Signature Date

Patient Name:_____

Attendance and Participation Policy

LAURIE ROSS BRENNAN & ASSOCIATES has a list of patients seeking speech therapy services. When we set up an appointment, a specific amount of time is reserved especially for you! In order for families receiving services to achieve maximum benefit from therapy and for therapists to maximize their time, it is necessary for us to enforce an attendance and participation policy. Research has shown that therapeutic progress cannot be made with poor attendance and tardiness. **Regular attendance at therapy sessions is highly associated with positive functional outcomes. Every minute of your child's therapy session is crucial for the achievement of your child's/family's goals. We are committed to checking in with you weekly, to including you and educating you in the therapeutic process, and to working with you to create a home program that best supports your child. In order to provide this level of care it is imperative that you are prepared to begin your session on time and that you actively participate in your child's session and/or in the creation and implementation of the home program.**

The policy is as follows:

1. **No Show** – A "No Show" occurs when you miss your scheduled appointment and do not notify LRBA. **You will automatically be charged $50 for each "No Show"**. After the second "no show" you will be notified that the next no show will result in your child being discharged from all therapies.

2. **Unexcused Absence** – An "Unexcused Absence" occurs when you do not notify your therapist 24 hours in advance of an absence. **You will automatically be charged a $25 fee for each "Unexcused Absence"**. We realize that unforeseen circumstances such as serious or contagious illness or emergencies may cause you to miss a scheduled appointment. These situations will be handled on an individual basis. A doctor's note or other adequate proof may be required. More than 3 "Unexcused Absences/No Shows" per quarter will result in the patient being discharged from the therapist's caseload.

3. **Absence** – An "Absence" occurs when you notify your therapist more than 24 hours in advance so that they may plan accordingly. A therapist is rarely able to fill a cancelled session time slot without 24 hours notice. Excessive absences may lead to discharge.

4. **Tardies** – You are considered tardy if you have not arrived within 5 minutes of the scheduled start time or if you are not available to check in with your therapist 10 minutes prior to the scheduled ending time. Late pick-ups are not manageable. After the second tardy, you will be notified that **further tardies will result in a $10 fee.**

We at LRBA strive to provide excellent and reliable service and we hope that this policy will help us to better serve all of our patients.

Thank you,
LRBA

_____ _____ _____

Signature Date Relationship to Patient

PATIENT INFORMATION AND EMERGENCY FORM

Patient's Name: _____ Date: _____
Date of Birth: _____ Social Security Number: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ( ) _____

Father's Name: _____ Mother's Name: _____
Employer: _____ Employer: _____
Work Phone: _____ Work Phone: _____
Cell Phone: _____ Cell Phone: _____
Caregiver (if other than parent): _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

Please list any significant illnesses and medical conditions (environmental/food allergies, asthma, seizures, etc.): _____

_____

Please list current medications: _____

_____

Please list any medication allergies and adverse reactions: _____

_____

Please note medical history (prenatal care, birth, developmental milestones, operations, childhood illnesses, serious accidents): _____

_____

_____

In case of illness or accident, and you cannot reach me, you are authorized to notify:
Name: _____ Phone: ( ) _____
Relationship: _____
Name: _____ Phone: ( ) _____
Relationship: _____

If unable to contact anyone, please contact my physician and follow his orders:
Physician: _____ Phone: ( ) _____
Dentist: _____ Phone: ( ) _____
Hospital Preference: _____ Phone: ( ) _____

It is understood that the parent/caregiver is responsible for further emergency transportation and care:

Signed: _____ Date: _____

Authorization to Photograph: Yes □ No □
Authorization for Student/Volunteer: Yes □ No □
Authorization to Release Information: Yes □ No □
Authorization to Discuss Status in Waiting Room: Yes □ No □

Insurance Information and Verification Form

Patient's Name:_____ Date of Birth:_____ Date:_____
SS # of Patient:_____ Male [] Female []
Patient's Address: _____City:_____ State:_____ Zip:_____
Parent/Legal Guardian Name(s):_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Address (if different than patient): _____ City:_____ State: _____ Zip: _____
Referring Physician:_____Phone:_____Fax:_____

Primary Insurance Company: _____ _____/_____(initial/date)
Policy Holder Full Name: _____ Policy Holder Date of Birth: _____ Male [] Female []
Social Security # of Policy Holder: _____ Employer of the Insured: _____
Policy ID#: _____ Group #: _____

Secondary Insurance Company: _____ _____/_____(initial/date)
Policy Holder Full Name: _____ Policy Holder Date of Birth: _____ Male [] Female []
Social Security # of Policy Holder: _____ Employer of the Insured: _____
Policy ID#: _____ Group #: _____

For LRBA Use Only

Reference #_____ Verification Date:_____

Contact Person _____ Coverage Dates _____
Pay out of Network? Y or N Need Referral/RX? Y or N Is this Plan an ASO plan? _____
In Network Benefits:
Copay per visit $_____ Co-Insurance %_____ **Maximum # visits per calendar year** _____
Deductible per Calendar year: $_____ Will Pay _____%, Up to a maximum allowable of $_____
Deductible Met: Y or N Amount Met YTD $ _____
Out of Network Benefits (if applicable):
Copay per visit $_____ Co-Insurance %_____ **Maximum # visits per calendar year** _____
Deductible per Calendar year: $_____ Will Pay _____%, Up to a maximum allowable of $_____
Deductible Met: Y or N Amount Met YTD $ _____
Combined Disciplines? Y or N **Can client be seen at home, school, daycare, community?** Y or N

Authorization Required for Services to be Rendered? _____

	OT: Y or N	**PT**: Y or N	**SLP**: Y or N
Will Pay For:			
Will Pay For:	Eval: Y or N	Eval: Y or N	Eval: Y or N
	Auth # _____	Auth # _____	Auth # _____
	Dates: _____	Dates: _____	Dates: _____
	# of Visits: _____	# of Visits: _____	# of Visits: _____

Any limitations/plan exclusions to services rendered? _____

Can eval span over more than one D.O.S.? _____
Approved Codes (by discipline):

	Covered ICD-10 Codes (from requested codes):				Approved CPT Codes:
OT	1)	2)	3)	4)	
PT	1)	2)	3)	4)	
SLP	1)	2)	3)	4)	

Other: Any other insurance on file? Autism Benefit?

11/15 mw

REQUIRED DOCUMENTATION prior to start of treatment:

- □ Copy of Insurance Card (front and back)
- □ Insurance Verification Form
- □ Prescription from Referring Physician
- □ Prior Authorization (if necessary)

I verify that all information I have given on this form is correct. I authorize the release of any medical or other information necessary to process my insurance claims. I also authorize direct payment of medical benefits to Laurie Ross Brennan & Associates by my insurance carrier for the services provided.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Patient Name:_____

New Patient Orientation Checklist

Thank you so much for trusting us with the care and treatment of your child. We will strive to support you in advocating and growing with your child by providing cutting edge treatment interventions in a safe, comfortable, and welcoming environment. At the same time, this is a medical office setting and we have some general guidelines to follow in order to ensure that we can provide high quality service to all of our patients.

Initials

_____ Please arrive 10 minutes early to sign in at the desk and take care of any co-pays or questions with the office staff. You will be given a therapy note(s) for all therapies scheduled that day that you must give to your therapist(s) before you are able to begin your treatment session.

_____ Please wait in the waiting room until you are escorted back to the clinic by your therapist. If you are not attending your child's therapy, please keep sibling(s) in the waiting room with you and if you bring food, clean up after yourself. If you and your therapist agree that it would be most beneficial for you to attend the sessions, you must keep siblings in the designated observation area located in the clinic gym for their safety.

_____ If you are not participating in your child's therapy session, please be available 10 minutes before the scheduled end of your therapy session so that the therapist may talk with you about the session, provide consultation regarding your child, update your home program, or answer any questions you may have.

_____ It is very important that you arrive and pick up your child on time. Being late to pick up your child is not manageable for our therapists, staff and their schedules.

_____ Please silence your cell phones and electronic devices in the waiting room. If you must answer a call, please go outside to have the conversation. Use of cell phones or other electronic devices is prohibited in all treatment spaces. We strive to create therapeutic environments and cell phone usage is disruptive during treatment sessions as well as to our hard working office staff and the other families in the clinic/waiting room.

_____ Patient/family bathrooms are located in the hallway. A changing table is located in the first hallway bathroom and health standards require that soiled diapers are placed in the plastic bags available and taken with you.

_____ If you request a service above and beyond the scope of your insurance coverage, we will need to bill you privately for that service. Upon your request and as per our LRBA Private Pay and Consultation rates, we can perform additional services such as attending family or team meetings, school observations/recommendations, providing extra reports, and extensive home programs or phone consultations.

_____ In the event that there is an unpaid balance on your account, we will make an attempt to set up a payment plan that is affordable and convenient for you. If your balance remains unpaid, the therapist will be notified that they must discharge the patient from therapy.

_____ We often have children in the clinic that have allergies/phobias. Certified assistance or therapy dogs are allowed into LRBA for treatment purposes, but pets are not allowed in the waiting room or any part of the clinic.

Thank you in advance for your adherence to these guidelines so that we can make you and your child's experience at LRBA as effective and positive as possible.

_____ _____

Parent/Guardian signature Date

Please provide us with an e-mail address to receive reports and/or any information from LRBA:

_____

LA2016

Medical Claim Management, Inc.
1830 Bosque Farms Blvd.
Bosque Farms, NM 87068
Ph: (505) 866-6805
Fax: (505) 866-5078

Greetings,

Medical Claim Management, Inc. is contracted with Laurie Ross Brennan & Associates to handle all of their insurance and patient billing requirements. We are available Monday thru Friday, 8:00 am to 5:00 pm to answer any questions you may have concerning your statement.

Our commitment to you is to assist you with any questions or problems you may have concerning your billing account.

MCM has been a Medical Billing Service since 1997 servicing the state of New Mexico, with over 38 years of experience in Medical Billing.

The following values guide our support:

- Commitment to Excellence
- Responsive Service
- Integrity
- Respect
- Value

Please contact our office whenever you have questions or concerns regarding your billing statements or insurance claims. We look forward to working with you.

Specializing In New Mexico's Healthcare Needs