CLIENT REGISTRATION

Date: _____
Child's Name (please print): _____

Date of Birth: _____ Age: _____ Gender: __ Male __ Female

Address: _____

Primary Phone: _____ Email: _____

Person Who Referred You: _____

You may contact me through: _____ email _____ text messaging _____ voice mail

Primary Care Physician Information:
Primary Care Physician: _____

Address: _____

Physician's Phone: _____

Physician's Fax: _____

Insurance Information:
Primary Insurance Company: _____

Claims Address: _____

Phone Number: _____ Insured's Name: _____

Insurance Plan Name: _____ Insured's Date of Birth: _____

Insured's Policy/Group #: _____ Insured's ID#: _____

Insured's Address: _____

Employer's Name & Address: _____

The above stated information is complete and true:

Signature of parent or guardian: _____ Date: _____

AUTHORIZATION FOR PAYMENT & RELEASE OF INFORMATION

I authorize Tara Todd Farris, LLC to submit health insurance claims for services rendered and to release any information pertaining to filing and documentation for any insurance claims.

I authorize Tara Todd Farris, LLC to receive payment directly from my insurance company. If my insurance company sends payment to me for services provided for Tara Todd Farris, LLC, then I understand I must remit payment to Tara Todd Farris, LLC within five days of receipt.

I agree that I have fully disclosed all insurance coverage and the information is correct to the best of my knowledge. I understand it is my responsibility to inform Tara Todd Farris, LLC of any changes to my insurance coverage. I am aware that if Tara Todd Farris, LLC does not have adequate health insurance on file for me that the charges incurred are my responsibility to pay out of pocket.

I hereby give my consent to Tara Todd Farris, LLC to use or release all medical records for the purpose of carrying out and coordinating therapy services to physicians, therapists, health care professionals, insurance companies and attorneys involved in my/dependent's care with the following exception:

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do to Tara Todd Farris, LLC. Written revocation of consent must be given, mailed or faxed to Tara Todd Farris, LLC.

Date: _____

Patient's Name: _____

Relationship to Patient: _____

Signed: _____

Food Permission/Dietary Information

Please complete the following information to inform the therapist of your child's dietary restrictions, and to allow your child to participate in oral-motor/feeding activities involving food items.

_____ My child may participate in food activities and has no diet restrictions.

_____ My child may participate in food activities if the following diet restrictions are observed (please include restrictions below):

_____ My child may participate in food activities; however, I will provide his/her food items.

_____ My child should not participate in food activities. I understand that this may impact the progress of his/her treatment.

_____
Child's name

_____ _____
Parent Signature Date

CANCELLATION POLICY

Please sign the following form in order to indicate that you have read and understand the cancellation policy.

This policy is effective January 1, 2005.

If a cancellation is made less than 4 hours prior to your scheduled session, you will be charged for the total cost of the session.

Please note that if a child is ill, use your best judgment as to whether or not to cancel his/her therapy session. If a child is easily contagious, then the session should be cancelled. In all other instances, parent judgment is acceptable. If your child becomes ill within four hours of his/her session, please notify the therapist as soon as possible prior to the session. It will be determined at that time if the cancellation fee will be waived.

In the instance of emergency within four hours of the therapy session, please contact the therapist as soon as possible. It will be determined at that time if the cancellation fee will be waived.

In the instance of vacation or other conflict, please alert the therapist when you are able so that she may adjust her schedule accordingly.

You may call your therapist on her mobile phone or Tara at 773/960.6607 at anytime to cancel a session.

Thank you for your cooperation with these procedures.

_____

Child's Name

_____ _____

Parent Signature Date

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act Privacy Rule (HIPAA) is a regulation that requires that I, Tara Todd Farris, make sure that your medical information is kept private and that I notify you of my privacy practices with respect to your medical information.

Medical Information

Your records may consist of your child's evaluations, diagnosis, daily notes, Individual Family Service Plan (IFSP), insurance information, physician prescriptions, and correspondence to your other medical providers (e.g. physicians, therapists, service coordinators, medical equipment companies, etc.).

Collection, Storage, Disclosure and Disposal of Medical Information

- My policy has always been to keep your records safe.
- Your records are usually kept in a folder of papers with your child's name on it. These files are stored in a locked desk drawer or locked office. Your records can also be stored in a computer, tablet or my cellular device, only accessible to myself. The digital records are password protected with two layers.
- I may receive your child's medical information through the mail, email or by fax electronically, which is limited for my use only. My facsimile and email transmissions protect your child's health information with the use of a confidentiality statement and password.
- Your medical information will only be shared with your physician, teachers or other service providers.
- Your medical records will be kept and stored for a minimum of six years. Your records will then be disposed of by shredding.

Your Rights Under HIPAA

- You have the right to inspect and copy your child's personal information. The request must be made in writing to myself.
- Your child's personal health information will be used strictly for evaluation and treatment planning.
- Your child's personal health information will be requested and shared only with those parties of which you have provided written consent.
- A written record of all disclosures of your child's personal health information will be kept.
- You have the right to complain if you believe your privacy rights have been violated. You may file a complaint by writing to me at the following address:

Tara Todd Farris, MHS, CCC-SLP*
3639 N. Hoyne Avenue
Chicago, IL 60618

You may also file a complaint with the Secretary of the Department of Health and Human Services. I will not retaliate or take action against you for filing a complaint.

_____ _____

Parent Signature Date

*designated HIPAA privacy officer

RELEASE OF INFORMATION

I, _____, parent of _____,

authorize the release of pertinent medical and educational information regarding my child to my child's primary care physician or other service providers to Tara Todd Farris, LLC.

_____ _____

Parent Signature Date

_____

Parent Name (printed)

SPEECH-LANGUAGE TREATMENT AGREEMENT

I am enrolling my child, _____, in speech-language treatment with Tara Todd Farris, LLC to begin on _____. Tara Todd Farris, LLC will bill my private insurance directly for the consultation, evaluation and treatment of my child. I agree to pay the fee of $180.00 per treatment session, and evaluations are billed at $360.00. Any co-insurance, cancellation fees or deductibles for services are payable directly to Tara Todd Farris, LLC.

_____ _____

Parent Signature Date

_____

Parent Name (printed)

_____ _____

Tara Todd Farris, MHS, CCC-SLP Date
Speech-Language Pathologist