CHAT
LIFE CHANGING
SPEECH THERAPY

310-D S. Main Street
Lombard, IL 60148

P 630.652.0200
F 630.652.0300

www.chatwithus.org

Therapy/Annual Client Forms

Dear CHAT Family:

Please find enclosed CHAT policies including our consent for services, privacy practices, attendance policy, and sick policy. We appreciate you reviewing and signing these policies prior to beginning therapy as well as updating them each calendar year, so we can best serve your family. Once these are completed, please upload to your client's Central Reach client portal. Please let our staff know if you have any questions.

Thank you!

CHAT staff

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Update of Physician and Insurance Information Form

Please complete with updated information regarding the client's current information

Client Name:____________________________________Date of Birth: _____________

Address:____

City:______________________________State:________zip: _____________

Child's Physician: ____

Physician's phone number: ____

Physician's Address: ____

Medical Insurance:____________________Id #________________Group #_________

Primary policy holder name: ____

Policy holder date of birth: _______________________________

____   _________________

Person completing this form   Date

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NOTICE OF PRIVACYPRACTICES

This notice describes how medical information about you or your child may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Our commitment here at CHAT (Communication Health, Advocacy & Therapy) is to serve our clients with professionalism and caring, while protecting the privacy and security of all Protected Health Information.

CHAT is committed to obeying all federal, state and local laws and regulations regarding privacy practices. It may become necessary to share information with other healthcare providers or third parties, such as insurance carriers and primary care physicians. If any other uses or disclosures are needed, information will only be released with the written authorization of the individual or parent/legal guardian in question. For example, we may recommend sharing information with other therapists and your school district. Express authorizations may be revoked at any time by the individual or parent/legal guardian, as provided for by law.

If you believe you or your dependent's privacy rights have been violated, you may file a complaint with us or with the secretary of the Department of Health and Human Services and you will not be penalized in any way for filing such a complaint.

If you have any questions or comments regarding your Protected Health Information, feel free to us at (630) 652-0200 or at scheduling@chatwithus.org.

Please sign below to indicate that you have read and understood the above Notice of Privacy Practices.

I acknowledge that by typing my name below, qualifies as my signature and indicates I have read, understood, and acknowledge the above policy.

Parent/Guardian Name: ______________________________

Signature:______________________________Date____________

Client/parent or Legal Guardian

Client Name: ______________________________

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Consent for Services

Client Name:_______________________________________Date of Birth:_____________

Address: ____

Name of Legal Guardian, if applicable: ____

Please read statements below:

- I hereby give consent for the above-named client to receive professional services at CHAT- Communication Health, Advocacy, & Therapy.
- I hereby verify that I have received and understand the Privacy Policy.
- I understand that CHAT is a fee for service office and that I am responsible for any payments due at the time of service.
    - I understand that CHAT will attempt to bill my insurance plan, and agree to provide CHAT with the information it needs to do so.
    - I understand that I am responsible for expenses beyond those my insurance covers, such as deductibles and co-pays, and commit to making those payments at the time requested
    - I acknowledge it is my responsibility to understand my insurance coverage and benefits, including my out-of-pocket obligations under my plan
    - I further understand that if my insurance does not cover CHAT services for any reason, I am responsible for payment in full.
    - I acknowledge that if my insurance has not paid out a claim 90 days after submission I can be invoiced for claims.

I have read and accept the terms and conditions of the above statements.

I acknowledge that by typing my name below, qualifies as my signature and indicates I have read, understood, and acknowledge the above policy.

____
Parent/Guardian Name

____
Client/Caregiver Signature for Consent Date

____
Relationship to client

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Attendance/Schedule/Cancelation Policies

THIS NOTICE DESCRIBES CHAT'S EXPECTATIONS FOR REGULARLY SCHEDULED SPEECH-LANGUAGE THERAPY SESSIONS. PLEASE REVIEW IT CAREFULLY.

- Therapy sessions are 40 minutes long. We generally recommend twice weekly therapy for consistency and impact but will be provided with specific recommendations based on client needs.
- Clients cannot be scheduled bi-weekly. Bi-weekly sessions are considered "maintenance therapy" and are not covered by insurance. It is sometimes possible to schedule family trainings twice a month. Please speak to an office staff member for more information.
- Clients are expected to keep an average of 80% attendance record for each treatment plan period in order to keep their preferred date/time slot each week; a warning letter will be provided if attendance falls below 80%.
    - CHAT requires at least 24-hour notice to cancel a therapy session.
    - Two consecutive no-shows will result in removal from the speech-language therapy slot.
    - Greater than 20-minute tardiness for a therapy session will be considered a no-show. Please honor our schedule; appointment times will be shortened if you are late.
    - Excessive and/or frequent tardiness to appointments may result in attendance warnings and/or discharge from therapy services until you are able to commit to consistent and timely attendance
- Children must not be left unsupervised in the waiting area.
- We generally recommend parents/guardians participate in therapy sessions, following guidance of their therapist. Parents/guardians not participating in sessions are required to remain at CHAT, absent express consent from a member of our staff. Permission can be denied if there are concerns for client or staff safety. Permission can also be revoked if a parent/guardian is consistently tardy in returning to CHAT at the end of the session.

CANCELATION POLICY

- Families will be charged a $50 fee for no-shows and cancelations with less than 24-hour notice.
- Families are given three "free passes" per year for unexpected circumstances and sickness before this fee will apply.

I have read and understand the above Attendance, Schedule, and Cancellation Policies.

I acknowledge that by typing my name below, qualifies as my signature and indicates I have read, understood, and acknowledge the above policy.

Parent/Guardian Name: ____

Client/Caregiver Signature: ______________________________Date___________

Client Name:____

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SICK POLICY

PLEASE REVIEW THIS DOCUMENT CAREFULLY.

For the protection of our clients and staff we ask that you please keep sick children at home and notify our office staff as soon as practicable.

Please keep your child home if:

- They have a fever of 100 degrees or higher. A child must be fever free for 24 hours before they return for therapy.
- They have been vomiting or have had diarrhea in the past 24 hours. All symptoms must be gone for 24 hours before they can return to our clinic.
- They have any unexplained rash or eye infection until a doctor has determined that it is not contagious.
- They have a severe active cold that includes a very runny nose and/or a bad cough.
- They have any COVID symptoms and have not tested negative.

These policies are meant to serve the best interest of all the children, staff, and families at CHAT. If your child shows up at the clinic with any of the above symptoms, we may need to cancel that day's session and will attempt to reschedule as able.

We greatly appreciate your cooperation. If you have any questions or concerns, please contact our Director, Kathleen Trainor, at (630) 652-0200.

I have read and understand the above Sick Policy.

I acknowledge that by typing my name below, qualifies as my signature and indicates I have read, understood, and acknowledge the above policy.

Client Name: ____

Parent/Guardian Name:_________________________________Date: ________________

Client/Caregiver Signature: ____

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Photo and Recording Consent

Client Name: ____

Parent/Guardian Name: ______________________________________

I give permission for Communication Health, Advocacy & Therapy (CHAT) and its agents to video/photograph or screen-record me and/or my child for the following purposes *(please check all that apply)*:

☐ **Media Consent**

- Videos/photographs/recordings may be used for promotional purposes, such as advertising or social media, by CHAT and/or forwarded to others for educational or commercial programs. All videos or photos will remain the property of CHAT unless taken by a media organization.
- I allow CHAT to share the following information publicly along with the video/photograph *(check all that apply)*:
  - ☐ Client First Name
  - ☐ Client Age
  - ☐ City, Town, or Village of Residence
  - ☐ Diagnosis/Treatment

☐ **Educational Consent**

- Videos/photographs/recordings and case history information may be shared with professionals in the field to educate on the skills and strategies being performed by the speech-language pathologist. With your help, we will be able to spread our knowledge and expertise to make necessary services more easily accessible. Thank you for helping us achieve our vision.

☐ **Referral Consent**

- I give permission to CHAT to give the following information to other parents/guardians/clients who are interested in or receiving CHAT services (*check all that apply*):
  - ☐ Name
  - ☐ Email
  - ☐ Phone
  - ☐ Location (City, State/Province, etc.…)
  - ☐ Relation to client

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OR

Please choose 1 of the following:

☐ **Medical File Consent**

- Videos/photographs/recordings will *only* be shared directly with parents/guardians via a secure method and necessary CHAT employees privy to client's medical files.

☐ **Deny Photo/Video/Virtual Recording Consent**

- I do *not* consent for CHAT to take any photo, video, or recording of me and/or my child.

I acknowledge that by typing my name below, qualifies as my signature and indicates I have read, understood, and acknowledge the above policy.

______________________________ Signature of Client/Parent/Guardian

___________ Date

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Client Name:_______________________________ Date of Birth: ______________

Parent/Guardian Name: ____

I hereby give consent to the following people (other than parent/guardians listed on client's case history, e.g. nanny, grandparent, etc) to discuss information regarding my child:

Name:_____________________________________Relation: ____________________

Phone Number:______________________Email:______________________________

- ☐ Therapy progress & performance
- ☐ Scheduling updates (clinic closure, SLP on PTO)
- ☐ Scheduling decisions (selecting therapy day/time)
- ☐ Billing & insurance information

Name:_____________________________________Relation: ____________________

Phone Number:______________________Email:______________________________

- ☐ Therapy progress & performance
- ☐ Scheduling updates (clinic closure, SLP on PTO)
- ☐ Scheduling decisions (selecting therapy day/time)
- ☐ Billing & insurance information

Name:_____________________________________Relation: ____________________

Phone Number:______________________Email:______________________________

- ☐ Therapy progress & performance
- ☐ Scheduling updates (clinic closure, SLP on PTO)
- ☐ Scheduling decisions (selecting therapy day/time)
- ☐ Billing & insurance information

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Child Emergency Health Information Form

Client Name____________________________Date of Birth:________________
Address:______________________City:______________St:____Zip:_______
Parent/Guardian Name:____
Home Phone:______________Cell:______________Work Phone:____________
Insurance Type/No:______________________Medicaid No.:________________
Physician:________________________Phone:_________________________
Address:__________________________City:__________________________

In the event of a medical emergency when a caregiver is not present, CHAT staff will first attempt to contact the child's parent or guardian. If that person cannot be reached, please list two *alternate* emergency telephone numbers of people the staff can contact to assume responsibility for the child:

1. Name__________________Relation_____________Ph/Cell_______________

2. Name__________________Relation_____________Ph/Cell_______________

Does the child have asthma, allergies and/or adverse reaction to medications:
☐ No ☐ Yes–- Please explain:____

Does the child have a seizure disorder or other serious condition (heart issue, diabetes, etc.):
☐ No ☐ Yes–- Please explain:____

Are there any foods the child cannot eat?
☐ No ☐ Yes–- Please explain:____

Is the child presently taking any medications?
☐ No ☐ Yes–- Please explain:____

Does your child have any birthmarks, scars, etc.?
☐ No ☐ Yes–- Please explain:____

Medical Emergency Release

In the event of a serious medical event:

- I give permission to CHAT to contact 911 in the event of a medical emergency involving my child and release any pertinent medical information to the medical staff providing care.
- I understand that if my child has a serious medical condition, I as the parent/guardian am responsible for remaining in the CHAT clinic, monitoring my child and providing all care necessary for my child's condition.

I acknowledge that by typing my name below, qualifies as my signature and indicates I have read, understood, and acknowledge the above policy.

____
Parent/Guardian Signature Date