Dear Parent(s) and or Guardian(s):

If you would like your child's speech and language skills evaluated and/or treated, I need you to submit the following (you can bring this to the initial evaluation):

1. Copy of the front and back of your insurance card. If your child has Medicaid, I only need the front side. I need copies of the FRONT and BACK of the card for all other insurance providers.

2. Please review and keep the Notice of Patient Privacy Practices information for your records.

3. Sign and Return the following:
    a. Patient Consent and Authorization Form
    b. Release of Information Form

4. Please complete the enclosed Case History form to the best of your ability. This will help me better understand and meet the needs of your child.

Thank you for your time and consideration. I look forward to working with you to facilitate your child's speech and language skills! If you have any questions, please feel free to call our office at (719) 688-8562.

Best,

Mallory Griffith M.A., CCC-SLP

Mallory Griffith M.A., CCC-SLP
612 College Ave, Room 21, Fort Collins, CO 80524
mallorygriffithslp@gmail.com

Permission to Screen, Evaluate, and/or Treat

Child's Name: _____ Gender: ☐ Male ☐ Female

Child's DOB: _____ Phone #: _____

Address: _____

Cell / Work #: _____ Email: _____

*Insurance Company: _____ Medicaid: ☐ Yes ☐ No

*Insurance/Medicaid ID # (Please include alpha characters):_____

Physician Name: _____

Physician Phone #: _____ Fax #: _____

Daycare/School Name: _____ Teacher's Name: _____

You will be contacted regarding the results of the screening. The therapist will only complete a full evaluation and/or subsequent treatment once they have spoken with you about the screening results and fees/insurance benefits. You will also be asked whether or not you would like your child to receive a comprehensive speech and language evaluation. If you agree to the evaluation, a licensed and certified speech pathologist will perform diagnostic measures (including standardized evaluations, clinical observations, parent/teacher report, and/or language samples, etc.) and provide subsequent treatment, if needed, to the above-mentioned child. Treatment/therapy is dependent upon the results of the evaluation, the recommendations of the responsible speech language pathologist and parental input. *Including your insurance information (optional) above will allow me to simply verify your benefits so we can share that information with you prior to evaluation/therapy, if needed. If your child is eligible for Medicaid benefits, Medicaid will cover 100% of all expenses. For all other insurance providers, you will be contacted to discuss your insurance benefits and course of recommended assessment/treatment, if treatment is recommended.

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Mallory Griffith WILL NOT bill you and/or your insurance company or begin evaluating/treating your child without discussing your benefits and plan of care with you.

_____ _____

Signature of Parent/Guardian Date

_____ Mallory Griffith M.A., CCC-SLP_____

Printed Name of Parent/Guardian Speech-Language Pathologist

Mallory Griffith M.A., CCC-SLP
612 College Ave, Room 21, Fort Collins, CO 80524
mallorygriffithslp@gmail.com

Notice of Patient Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to information. Please review it carefully. If you have any questions, please contact me at 1-719-688-8562.

WHAT IS MY LEGAL DUTY? Mallory Griffith is required by law to protect the privacy of health information that might reveal your identity. I am required to provide you this notice about our health information privacy practices and follow the information practices that are described herein. You will be asked to sign an “acknowledgement” statement, indicating that you have been provided with this notice.

WHO FOLLOWS THE POLICIES IN THIS NOTICE? • Mallory Griffith and any possible office staff or student-trainee affiliated with Mallory Griffith M.A., CCC-SLP. This notice refers to practices followed by Mallory Griffith. This notice refers to services provided at our office, the patient’s home or natural environment. Exceptions: If you receive treatment in a facility or location not owned or operated by Mallory Griffith, other policies may apply.

WHAT HEALTH INFORMATION IS PROTECTED? Federal laws define “Protected Health Information” (or PHI) as any individually identifiable health information. It refers to protected health information that is created or received by or on behalf of Mallory Griffith M.A., CCC-SLP; contained in the patient’s medical record or files, whether oral or recorded in any form or medium. SUMMARY OF THIS NOTICE 1. Uses And Disclosures Of Health Information Mallory Griffith uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that I provide. Mallory Griffith. may use your personal health information to communicate with you about treatment, obtain payment for service or conduct my business operations. (Example: to provide appointment reminders.) I may communicate information with you via telephone, fax, voice message, electronic/text message, email or other. However, I will obtain your permission to do so, or we are responding to an inquiry that you initiated via that method. Mallory Griffith may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. I also provide information when required by law. Mallory Griffith may use or disclose your health information if we have removed any information that might identify you. Mallory Griffith. does not sell or disclose your protected health information for external marketing. However, I may use it internally to contact you with

information about treatment alternatives or other health related benefits that could be of interest to you. In any other situation, Mallory Griffiths policy is to obtain your written authorization before disclosing your personal health information. If you provide me with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

You may request that I transfer your records to another person or organization by completing a written authorization form.

2. Patient's Individual Rights You have the right to access, inspect or obtain a copy of your personal health information at any time.

You have the right to request that I correct any inaccurate or incomplete information in your records.

You also have the right to request an accounting of disclosures, with the exception of routine disclosures for treatment, payment and business operations.

You may also request in writing further restrictions on how we use or disclose your personal health information. However, I am not not required to agree to the restriction you request unless you pay out of pocket, in full for services provided.

You have the right to request that I contact you in a way that is more confidential for you. I will try to accommodate reasonable requests. Mallory Griffith will consider all requests on a case-by-case basis, but the practice is not legally required to accept them. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control privacy of health information of minors unless the minors are permitted by law to act on their own behalf.

Mallory Griffith reserves the right to change its policy at any time. When changes are made, a new Notice of Privacy Practices will be posted in the waiting room and website. You may also request an updated copy of our Notice of Information Practices at any time.

3. Concerns and Complaints If you are concerned that Mallory Griffith may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, me at the address listed below.. No one will retaliate or take action against you for filing a complaint. You

may also send a written complaint to the US Department of Health and Human Services.

For further information on Mallory Griffith's health privacy practices or if you have a complaint, please contact: Mallory Griffith - 612 S. College Ave, Room 21, Fort Collins, CO 80524, mallorygriffithslp@gmail.com , or www.mallorygriffithslp@gmail.com

Mallory Griffith M.A., CCC-SLP
612 College Ave, Room 21, Fort Collins, CO 80524
mallorygriffithslp@gmail.com

Authorization of Release of Information

Completion of this form will serve as written permission for Mallory Griffith, MA, CCC-SLP, speech language pathologist to communicate with the individuals you have listed below for the purposes you identify. This authorization will be considered valid throughout the course of treatment unless otherwise requested by the patient and/or guardians.

Patient Name:_____

I authorize release of information by Mallory Griffith, MA, CCC-SLP, speech language pathologist, to (list names and contact information of individuals:

_____
_____
_____
_____
_____

For the purposes of (check all that apply):

_____Coordinating services, techniques, treatment strategies among other professionals (school personnel, pediatricians, audiologists, etc.)
_____Updating progress towards goals
_____Providing continuity of services (relocation, change of service provider, etc.)
_____Other:_____
_

Shared information may include:

_____*No restrictions, all information relevent/pertinent to coordinating patient treatment* - or-
_____Session notes only
_____Evaluations only
_____Informal progress updates only
_____Other:_____
_

Communication to/from these individuals may occur in a variety of ways (in person, phone conversations, e-mail, fax, etc.) and may include information from the patient's medical record, for example, speech-language evaluation results or effective speech-language therapy techniques. Please know you have the right to restrict how information about you or your child is shared. Kindly indicate any restrictions you wish to request regarding how information about you aor your child is shared with the above named individuals.

_____I do not have any restrictions about how my information is shared.
_____I wish to apply the following restrictions (no phone, e-mail, etc.):_____

Mallory Griffith M.A., CCC-SLP
612 College Ave, Room 21, Fort Collins, CO 80524
mallorygriffithslp@gmail.com

_

Signed:_____

Printed Name/Relationship to patient_____