POLICIES & PROCEDURES
HEADWAY REHABILITATION

PLEASE READ AND INITIAL THE FOLLOWING:

Informed Consent :

I consent for speech-language treatment procedures and care as provided by the speech-language pathologists at Headway Rehabilitation (hereinafter called "HR"). _____ (initial)

HIPAA Notice of Privacy Practices Acknowledgement:

I have received, read, and understand HR's Notice of Privacy Practices. _____ (initial)

Authorization to Release and/or Obtain Medical Records:

I hereby authorize all physicians participating in my healthcare and HR to release, use, and disclose my entire medical record by mail, phone, and fax, to carry out my treatment, payment, and healthcare operations. _____ (initial)

Payment :

I understand that HR accepts cash, check, and all major credit cards. I understand that fees are due at time of session. Checks should be made out to Headway Rehabilitation. There is a $25.00 fee assessed for all returned checks. _____ (initial)

Insurance:

I understand that HR does not directly file or accept insurance. However, HR will provide a detailed invoice, upon my request, so I may submit an insurance claim on my own. These invoices will include the total session charge, diagnostic codes, and procedural codes to provide the appropriate amount of information needed for insurance companies to process any potential reimbursement. Even if I decide to submit an insurance claim, I understand that all fees are due at time of session. I also understand that it is my responsibility to verify insurance coverage for speech therapy. Additionally, if your insurance company requires a referral or authorization, then it is your responsibility to obtain this prior to your appointment. _____ (initial)

Medicare:

I understand that HR does not currently accept Medicare. If I have Medicare coverage, I understand that I must read and accept/initial the following statements. If you do not have Medicare, then ignore this section.

1. Patient or his/her legal authorized representative agrees not to submit a claim (or to request that HR submit a claim) under the Medicare program for services provided by HR, even if such items or services are otherwise covered under the Medicare program. _____ (initial)
2. Patient or his/her legal authorized representative agrees to be responsible, whether through insurance or otherwise, for payment of services and understands that no reimbursement will be provided under the Medicare program for such services. _____ (initial)
3. Patient or his/her legal authorized representative acknowledges that that Medicare limits do not apply to what HR may charge for services. _____ (initial)
4. Patient acknowledges that Medigap plans do NOT, and other supplemental insurance plans may elect not to, make payments for services not paid for by Medicare. _____ (initial)
5. Patient acknowledges that (s)he has the right to obtain Medicare-covered items and services from other speech therapists who do accept Medicare. _____ (initial)

HEADWAY REHABILITATION

P. (843) 603-4567 | F. (843) 405-1321 | headwayrehab.org

Attendance Policy:

1. I understand HR requires 24-hour advanced notice to cancel my appointment. I understand HR reserves the right to charge a $25.00 fee if I do not give 24-hour notice. Insurance will not cover this fee. _____ (initial)
2. I understand if I cancel or do not attend 3 sessions in a row, HR will put my services on hold until scheduling problems can be worked out. Additionally, notifications will be sent to the referring physician, workers' compensation case manager, and/or attorney, if applicable. _____ (initial)
3. I understand if I am more than 15-minutes late for my appointment, HR reserves the right to cancel the appointment and consider it a missed appointment (see policy for missed appointments above). I understand if I am late for 3 or more sessions, HR may put my services on hold until scheduling problems can be worked out. _____ (initial)

Authorized Methods of Communication (choose between 1 & 2 below and then circle all that apply):

1. Okay to leave call back phone number only:	Home	Cell	Work
2. Okay to leave detailed message on answering machine/voice mail:	Home	Cell	Work

By signing below, I acknowledge that this form has been read in full and explained as necessary.

_____

Patient or Parent/Guardian Signature

_____

Relationship to Patient

_____

Date

HEADWAY REHABILITATION

P. (843) 603-4567 | F. (843) 405-1321 | headwayrehab.org