2601 70th Ave West, Suite E
University Place, WA 98466
253-212-3502 (phone)
888-972-1827 (fax)
info@fluenschildrenstherapy.com

AUTHORIZATION AND CONSENT FOR TREATMENT, PAYMENT, AND OPERATIONS

Please read the following statements and sign below for acknowledgement.

These statements only apply to clients utilizing insurance benefits:

- I understand a prescription from my child's physician is often needed to authorize the initial evaluation and therapy services if I am utilizing insurance benefits. It is my responsibility to obtain this when required by my insurance company.
- I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, deductibles, and co-insurance.
- I agree to pay Fluens Children's Therapy my cost share (coinsurance, copayment, % not paid by insurance, deductible) as agreed and stated in my insurance plan.
- I understand it is my responsibility to keep track of therapy visits used as well as the expiration date of the authorization and prescription. *When this date and/or limit approaches, please communicate with my therapist to initiate the re-authorization process.*
- I understand that it is my responsibility to notify Fluens Children's Therapy of insurance changes in order to prevent lapses in services or denial of payment.
- I understand that I will be financially responsible for any therapy services rendered that are denied by my insurance company. Claims that are unpaid for more than 90 days will become my financial responsibility, and any session unpaid for more than 120 days will go to a collections agency.
- I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.
- I, the undersigned, directly assign to Fluens Children's Therapy all medical benefits through my insurance provider. I give Fluens Children's Therapy permission to submit bills directly to the insurance carrier. I understand that I am

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financially responsible for all charges whether or not paid by insurance. I hereby authorize Fluens Children's Therapy to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all of my submissions.

The following statements apply to all clients and all funding sources:

I consent to the treatment necessary for my child, including speech therapy, feeding therapy, PROMPT therapy, and/or any other related services that the provider or physician advise to be necessary.

I hereby give Fluens Children's Therapy permission to evaluate and treat my child, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies (if using these benefits), and Fluens Children's Therapy staff.

I understand that payment is due at time of services rendered. If I choose to keep a card on file, Fluens will, as a courtesy to me, run my card once a week for the previously incurred charges.

I agree and accept the above terms and service agreements. I agree that the electronic signatures, whether digital or encrypted, included in this Agreement are intended to authenticate this writing and to have the same force and effect as manual signatures.

________________________________ ____________

Parent/Legal Guardian Date

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your child's privacy is important to us and, as required by law, we will protect the privacy of health information that you share. Our Notice of Privacy Practices will be posted at the location where we provide services and a copy will be available for you to download after submitting these forms. By signing below, you acknowledge that you are the parent/legal guardian of the client and have received a copy of Fluens Children's Therapy's Notice of Privacy Practices effective 4/1/2017.

____ _______________

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WAIVER OF LIABILITY, RELEASE AND ASSUMPTION OF RISK RELATING TO CORONAVIRUS DISEASE 2019/COVID-19

The coronavirus disease 2019 ("COVID-19") has been declared a worldwide pandemic by the World Health Organization. On February 29, 2020, a State of Emergency was proclaimed in Washington State as a result of the COVID-19 outbreak in the United States and confirmed person-to-person spread of COVID-19 in Washington State. COVID-19 disease is caused by a virus that spreads easily from person to person which may result in serious illness or death. COVID-19 has broadly spread throughout Washington State and remains a significant health risk.

As a result, the Governor of Washington State has issued Stay Home – Stay Healthy Orders, which initially prohibited all people in Washington State from leaving their homes or participating in social, spiritual or recreational gatherings of any kind regardless of the number of participants, and all non-essential businesses in Washington State from conducting business, within the limitations therein. Essential businesses are allowed to remain open, provided social distancing and sanitation measures established by the United States Department of Labor or the Washington State Department of Health are followed. Washington State has also adopted a phased-in approach to re-opening Washington State as set forth in the Safe Start Washington re-opening plan.

Speech pathologists and diagnostic and therapeutic technicians and technologists provide essential services and are permitted to conduct business provided that social distancing and sanitation measures are established as described in the Washington Stay Home – Stay Healthy Orders and the Safe Start Washington re-opening plan.

Fluens Children's Therapy, PLLC ("Fluens Children's Therapy") follows social distancing and sanitation measures as recommended by the Washington Stay Home – Stay Healthy Orders and Safe Start plan to reduce the spread of COVID-19. However, Fluens Children's Therapy cannot guarantee that you or your child(ren) will not be exposed to or contract COVID-19 by entering the business and receiving in-person therapy at Fluens Children's Therapy.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or contract COVID-19 by my child(ren) receiving in person therapy at Fluens Children's Therapy and that such exposure or contraction may result in personal injury, illness, permanent disability, or death. I understand that by entering the business and receiving in-person therapy at Fluens Children's Therapy, I could increase my child(ren)'s and my risk of

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being exposed to or contracting COVID 19. I understand that the risk of becoming exposed to or contracting COVID-19 at Fluens Children's Therapy may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Fluens Children's Therapy employees, members, agents, and clients and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s participation in in-person therapy at Fluens Children's Therapy. On my behalf, and on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless Fluens Children's Therapy, its employees, members, agents, and representatives, of and from all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating to my child(ren)'s participation in in-person therapy at Fluens Children's Therapy. **I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Fluens Children's Therapy, its employees, members, agents, and representatives, whether an exposure to or contracting of COVID-19 occurs before, during, or after participation in any in-person therapy at Fluens Children's Therapy.**

It is my express intent that this Waiver of Liability, Release and Assumption of Risk shall bind the members of my family, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a Release, Waiver, Discharge and Covenant Not to Sue the above named releases. I further agree that this Waiver of Liability, Release and Assumption of Risk is to be construed in accordance of the laws of the State of Washington and is intended to be as broad and inclusive as permitted by the laws of the State of Washington. If any portion hereof is held invalid, I agree that the remainder of the Waiver shall, notwithstanding, continue in full legal force and effect. The venue for any dispute that may arise out of this Agreement or otherwise between the parties shall be in the federal and local courts located in King County, Washington.

By typing your name below, you are consenting to the use of your electronic signature in lieu of an original signature on paper. You have the right to request that you sign a paper copy instead. By signing below, you are waiving that right. You may request a paper copy of the electronic record in writing at no fee at any time.

______________________________ ______________

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ATTENDANCE POLICIES

Fluens Children's Therapy strives to ensure your child receives the services that best fit his/her needs and that progress is being made in therapy. Regular attendance at therapy sessions is imperative in achieving this goal. Therefore, Fluens has the following policies regarding attendance:

Consistent attendance is necessary to achieve the discussed goals for treatment. Frequent absences or missed appointments will impact the success of therapy.

Please call us at (253) 212-3502 by 4:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 4:00 p.m. on Friday. If prior notification is not given, you will be charged $20 for the missed appointment.

If a patient arrives 15 minutes past their scheduled appointment time, we will have to reschedule and the $20 missed appointment fee will apply.

Any patient that misses more than 2 appointments in a six-month period will be removed from the reoccurring schedule and will be moved to our call-in list. Should those appointments be missed Fluens will no longer be able to offer therapy services.

All stated polices apply to both in-person and online (virtual) therapy sessions.

As a courtesy, Fluens will hold scheduled recurring appointment times for up to two weeks with advanced notice to accommodate vacations, family emergencies, etc.

It is the responsibility of the client and the therapist to be respectful of health concerns. Clients who are sick should not be seen for therapy and therapists who are sick will not provide services to avoid spreading illness. If your child shows symptoms of illness on the day of an appointment or has exhibited vomiting and/or fever within the last 24 hours, please contact our office as soon as possible. Should the therapist become ill, you will be contacted to reschedule the appointment.

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In the event medical attention is required for your child while on the premises of Fluens Children's Therapy, we need your authorization to implement treatment. As the legal guardian of the client, do you give permission for Fluens Childrens Therapy to contact emergency personnel in the event of a medical emergency?

We will frequently call you to discuss matters related to your child's therapy program. If we are unable to reach you on the phone number(s) provided, do you give consent for us to leave a detailed voicemail message?

Primary Contact Person:

Phone Number for Primary Contact:

Relationship of Primary Contact to the Client:

Alternate Contact Name:

Phone Number for Alternate Contact:

Relationship of Alternate Contact to the Client:

Would you like to be updated via email regarding upcoming events and topics related to speech, language, and social skills?:

How did you hear about us?:

General Developmental History

In order for us to better understand your child's needs and skills related to communication, please answer the following questions to the best of your ability. These answers will help us when designing a therapy program to suit your child. If you would rather discuss any question in person, feel free to write that as your response. Thank you in advance for your assistance!
Please describe the concerns regarding your child that brought you here today.

What school/daycare does your child attend?

Who is your child's pediatrician?

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What is the phone number for your child's pediatrician?

What languages are spoken in the home? Which of those languages does your child understand and use to communicate?

Who are the other people that live in your household, including ages?

Does your child have a history of seizures, serious illness, surgeries, or hospitalizations? If so, what were they and when did they occur?

Does your child have a medical diagnosis (e.g. Autism, ADHD, diabetes, etc.)? If so, what is it and when was the diagnosis received?

Please list the types of other services your child has received and when the services were received. Examples include other speech therapy providers, early intervention (Birth-Three), occupational therapy, counseling, etc.

Are you aware of any mental illness, developmental disorders, speech, language, or hearing problems in your family? If yes, please describe.

Please describe the conditions of your pregnancy and your child's birth: (full term, vaginal delivery, pre-eclampsia, maternal stress, baby's weight, etc.)

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Were there any delays in achieving developmental milestones, including sitting, standing, walking, first words? If so, please describe.

Does your child have a history of recurrent ear infections? If so, how were they treated?

Please list the date and results of the last hearing test your child had completed.

How well does your child understand you? Others?

Does your child follow: simple commands (e.g. put that away)? 2-step directions (e.g. get your shoes and brush your hair)? 3-step directions (e.g. pick up your toys, brush your teeth and get in bed)?

Describe your child's play (preferred toys, activities, people involved and time spent per day in these activities, solitary/with others).

Please describe things that make your child upset and what helps calm him/her.

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Does your child exhibit aggressive or destructive behaviors (directed at self or others)? If so, please describe.

Is your child often frustrated, anxious or overwhelmed? How can you tell?

Did your child babble during infancy?

Does your child use short phrases or sentences to communicate? If so, please give some examples.

Does your child answer various types of wh- questions (who, what, where, when, why)? Are there any that are a challenge?

How well can your child be understood by family members/familiar adults? Unfamiliar people?

Does your child make errors on specific speech sounds? If so, please describe.

How does your child compensate when not understood? (e.g., pull you to object, point to/show object, gesture, rephrase statements)

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Does your child imitate speech sounds? Words? Sentences?

Does your child have difficulty maintaining conversations? If so, please describe. (If your child is not yet verbal, please write N/A)

Does your child have challenges in reading social situations? If so, please give examples. (If your child is not yet verbal, please write N/A)

Please describe how your child interacts with his/her peers.