SPEAKeasy
Speakeasy Therapy Services LLC

7425 W. Azure Dr., Ste 140 Las Vegas, NV. 89130
2490 Paseo Verde Pkwy., Suite 155 Henderson, NV. 89074
3965 W. Cheyenne Ave., Ste 101 North Las Vegas, NV. 89032
6345 S. Jones Blvd., Ste 300 Las Vegas, NV 89118

Patient Name: _____ **Date:** _____

Thank you for choosing Speakeasy Therapy Services. We offer Speech, Occupational, and Physical Therapy. Your needs are what we specialize in.

Take comfort in knowing that here at Speakeasy we take the smallest details into account to provide the best possible care.

Treatment Authorization

_____I agree to allow Speakeasy Therapy Services to provide (ST, OT, PT) services for myself or my child/loved one.
____ I have discussed the treatment goals and therapy plan during the evaluation with the provider and I agree with all goals and therapy plans.
____ I agree to attend scheduled therapy sessions.
____ I understand that my child/loved one may be given work to do at home. I agree to help my child/ loved one, do this work to help with the outlined treatment goal
____ I understand multiple codes could be billed based on the goals and treatment plan

Speakeasy Therapy Services is committed to providing the best possible service to all of our patients. Please read the following attendance policy carefully. Initials and signatures are needed to receive treatment.

Attendance Policy

1. **Scheduling:** We understand schedules outside of Speakeasy can be hectic, our scheduling department will do everything we can to accommodate you as much as possible. After a patient has been scheduled, it is the patient/parent/guardian's responsibility to make it to all scheduled appointment(s). Speakeasy will do all that is needed to ensure each patient understands their schedule. With that in mind printed versions of schedules are available upon request. _____

2. **Text Reminders:** Text reminders are sent as a courtesy the day before your scheduled appointment. Please confirm or cancel your appointment so we know if you are coming or if we can offer the appointment to patients who are on the fill-in list or waiting list. If you are not receiving text reminders please verify your phone number with the front desk. Please keep in mind sometimes text messages may not be sent or in some cases not be received **AGAIN THIS IS A COURTESY** as all patients/parents should be aware of their recurring appointments. If we text/call to confirm and there is no answer Speakeasy is going to assume that the patient **WILL** be at their scheduled appointment _____

3. **Cancellations/No Shows:** Please cancel all appointments 24 hours or more in advance with the scheduling department. If an appointment is not canceled at least 24 hours in advance a **$35** charge per missed therapy session will be administered. This charge is not covered by insurance. **All patients need to reschedule any/all missed appointment(s), see below**.** _____

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Continuation of Attendance Policy

4. **Missed appointments:** Regular attendance is required when you have a recurring appointment which includes telehealth. Regular attendance is needed for the patient to be successful in reaching their goals; insurance companies are reviewing attendance when determining if re-auth is requested/needed; and for the patient's continuity of care. **A patient with a recurring schedule is permitted to miss 1 appointment during a 4 week period specific to the day of the week (as you may have multiple days of treatment). If removed from a recurring schedule the patient will be placed on a "fill-in/cancellation" call list until consistent attendance can be maintained. If the patient has canceled 2 times in a row OR If the patient has 2 NCNS they will be immediately removed and put on the fill in list. NCNS DEFINITION: No call before scheduled appt time and/or not on property for scheduled appointment time.**

5. **Rescheduled appointment(s):** If R/S appointment is missed and another reschedule is requested it will only be available 1 time per missed appointment. If reschedules are requested consistently then a new day/time will be offered. Recurring appointments are for patients who need a scheduled day/time every week. All other appointments should be scheduled around this weekly scheduled appointment. Rescheduled appointments don't offset the initial cancellation OR charges assessed for less than 24 hr cancellations. If a recurring schedule change is needed please notify us within 72 hours prior to your appointment.

6. **Unforeseen illness, injury and/or COVID related issues:** **To maintain current recurring appointment time** Speakeasy Therapy will need a physician note and any missed appointments will need to be rescheduled upon returning to therapy if the absence is more than 1 appointment missed but doesn't exceed 2 missed appointments on any day. In lieu of a Doctor note for COVID we will accept a negative test result. All unforeseen cancellations need to be approved by a supervisor._____

7. **Late Appointments:** If a parent/patient is going to be late it is the parent/patient's responsibility to notify our office. Lateness in excess of 10 minutes may require your appointment to be rescheduled. It is imperative if the patient has a 30 minute session to be on time.

8. **Clinician Cancellations:** In the event a therapist is out of the office we will make every effort to find coverage for the appointment with another therapist. If we are unable to do so we will contact you as soon as possible to reschedule or cancel the appointment. If another therapist is available the same day or a reschedule is declined by the patient/parent this will be considered a "missed appointment". If we are not able to reschedule within your availability or find another provider to treat the patient then this WILL NOT count against your attendance. _____

As a courtesy we will attempt to remind you of our attendance policies when/if needed. However, it is a courtesy and removal due to attendance policy can/will take place if we are/aren't unable/able to reach a parent/patient and/or should we not receive a response from the parent/patient. If you desire for immediate discharge rather than the "fill-in cancellation list" please notify us by calling or text.

Removal temporarily from the schedule for a break is for a period of 30 days. If the break needed exceeds 30 days we will discharge patient and new referrals will be needed if you would like to return to therapy.

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ZERO TOLERANCE POLICY

Speakeasy Therapy Services enforces the policy of "zero tolerance" according to which, the aggressive behavior of patients or parents towards all staff (administration and providers) will not be tolerated. It is a great honor for Speakeasy Therapy to have all the patients who have trusted this office and its services.

We welcome feedback in regards to the medical services the office(s) provide. However, we will not tolerate anyone doing so by being rude and/or offensive.

The examples of behavior that will not be accepted include:

- Physical violence toward any staff member
- Abusing any staff member with foul language
- Persistent or unrealistic demands that cause stress to staff members will not be accepted. Requests will be met wherever possible and explanations given when we cannot accommodate the request
- Verbal abuse towards the staff in any form including but not limited to verbally insulting or intimidation of the staff with threatening language
- Shouting at any staff member
- Racist remarks or racism towards any staff member

Any patient who violates this policy will be immediately discharged from this facility without warning.

Dear Parents/Guardians,

The safety and wellbeing of your child is our highest concern. Therefore, effective January 1, 2022, you will need to remain at the facility, and be immediately available to staff for the duration of your child's therapy session.

During the session, if you leave or want to wait in your vehicle, staff must be able to immediately reach you by phone so you can return to the facility within 5 minutes.

This policy is being implemented to mitigate issues which have occurred in the past. Examples include:

- Parents not returning for their child at the completion of the session.
- Unscheduled restroom breaks during the session that staff cannot facilitate.
- Behavioral challenges which require immediate parental intervention, etc.

PLEASE NOTE: EFFECTIVE 04.01.24-If you leave property and are not able to be reached or return to the facility within the 5 minutes indicated above the following fees and course of action will apply: Late 0-10 minutes $20.00 fee will be assessed and every 10 minutes thereafter an additional $20.00 will be assessed up to a total of $60.00. If you are late beyond 30 minutes we will have no alternative but to contact CPS and our local law enforcement. This is based on recommendations from CPS. Payment of fees will be done upon picking up your child or before their next treatment session. Non-compliance will result in loss of services.

Thank you for your understanding and cooperation. By signing below you are agreeing to this new policy.

Patient's printed name _____Date_____

Parent's signature _____

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Speakeasy Therapy Services, LLC

HIPAA Privacy Notice

Speakeasy Therapy Services, LLC is required by law to keep your health information safe. This information may include:

- notes from you/your child's doctor, teacher, or other health care provider
- you/ your child's medical history
- you/your child's test results
- you/your child's treatment notes
- insurance information

We are required by law to give you a copy of our privacy notice (attached in the back of this packet). This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

By initialing and signing this document you are saying that you have been given a copy of our privacy notice.

_____I acknowledge that the HIPAA Privacy Notice has been provided to me to review.

_____ _____
Print Patient's Name Date

_____ _____
Patient or Parent/Guardian Signature Date

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Speakeasy therapy Services, LLC

Authorization for Release of Information

Patient Name: _____ Parent/Guardian Name: _____

Check all that apply

Entity To Receive Information	Description of information to be released.
__Parent/Spouse Name: _____	__Test Results/Evaluations/Notes __Financial Information __Medical Information __Test Results/Evaluations/Notes
__ Hospital Name:_____	__Test Results/Evaluations/Notes __Financial Information __Medical Information __Test Results/Evaluations/Notes
__ Primary Pediatrician/Doctor Name: _____ *associated nursing staff*	__Test Results/Evaluations/Notes __Financial Information __Medical Information __Test Results/Evaluations/Notes
__ Voicemail __ Text	__Test Results/Evaluations/Notes __Financial Information __Medical Information
Other (in case may bring child)_____ Grandparents Name:_____ Aunt/Uncle Name:_____ Friend Name:_____ Sibling Name:_____ Other Provider (Lactation, Dentist, etc) _____	__Test Results/Evaluations/Notes __Financial Information __Medical Information __Test Results/Evaluations/Notes

This authorization will expire: _____(date). By not adding a date, this document will remain effective until revoked by the patient.

I understand that:

I have to sign in order to receive authorization and treatment

- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- The person or organization that gets my health information because of this authorization may have the right to share it with others without my permission.

I allow a Picture release for Clinic Source for the therapist to ID the child during coverage, etc.

_____ _____

Patient (or Parent/Legal Guardian) Signature Date

_____

Printed Name

If you would like more information about our privacy practices or have any questions or concerns please reach out to us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations you may file a complaint with us using the contact information listed at the end of notice. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address upon request so you are able to file your complaint.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health and Human Services.

Speakeasy Therapy
(702) 515-4009

_____ _____

Patient (or Parent/Legal Guardian) Signature Date

_____

Printed Name

SPEAKeasy
Speakeasy Therapy Services, LLC

Agreement of Financial Responsibility

_____ We will confirm your insurance coverage prior to treatment and obtain authorization if required. **This is not a guarantee of payment.** If no payment is received upon submitting our claim(s), you will be financially responsible. It is your responsibility to know your own insurance benefits, your covered benefits and any exclusion in your insurance policy.

_____ It is your responsibility to provide **current and accurate insurance information**, including any updates or changes in coverage. **Should you fail to provide this information, you will be financially responsible for the full evaluation and/or treatment cost billed to the insurance company.**

_____ Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that services will be covered by your insurance.

_____ If we are not contracted with your insurance OR if benefits are Out of Network, you will be expected to pay for all services rendered prior to receiving treatment. We will provide you with a statement that you can submit to your insurance for reimbursement.

_____ Understand if your insurance has Out of Network benefits that the coinsurance or copay will be higher and has limited annual benefits. If you receive services as part of an Out of Network, your portion of financial responsibility will be higher than your In-Network rate.

I have read the financial policies contained above and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand if my insurance company denies coverage and/or payment for services provided, I assume financial responsibility and will pay all such charges in full.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (print) Relationship to Patient

SPEAKeasy
Speakeasy Therapy Services, LLC

Patient Financial Responsibility Form

Thank you for choosing Speakeasy Therapy Services, LLC. as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies, which are as follows:

1. The **patient (patient's guardian)** is ultimately responsible for the payment of his/her treatment and care.
2. The patient is responsible for missed appointment charges as outlined above in **Attendance Policy**. The patient is responsible for charges associated with forms of completion.
3. The patient is responsible for any costs associated with collections of patient balances.
4. Patient statements can be mailed (or emailed) monthly upon request. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement.
5. The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency)

____ Your signature below forms a binding agreement between Speakeasy Therapy Services, LLC (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the parent or legal guardian to the Patient or the individual who is financially responsible for payment of medical bills.

____All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We do accept a variety of different medical insurances which we will bill as a service to you.

_____ As the Responsible Party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform SPEAKEASY THERAPY SERVICES, LLC of the **current address and phone number for the patient and the responsible party, change in insurance (give new card)**
- Present **all current insurance cards prior to each office visit.**
- Verify at each visit that the information is current by signing our check in sheet.
- Pay any required copay PRIOR TO time of visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. *(When Speakeasy Therapy receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.)*

Returned Check Policy:
If a payment is made on an account by check, and the check is returned as non-sufficient funds, Account Closed, or Refer to Maker, the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check. If a response is not made within 15 days from the letter date by the Patient or Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance- in addition to the $25.00 check Service Charge.

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Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that Speakeasy Therapy Services, LLC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including 33% added to outstanding balance, all court costs and Attorney fees. By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the Responsible Party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Printed name of Responsible Party: _____

____By my signature below, I hereby authorize the assignment of financial benefits directly to Speakeasy Therapy Services, LLC. and associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____

Patient (or Parent/Legal Guardian) Signature Date

_____

Printed Name

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for charges and submit the claims to my insurance company at my discretion.

_____ _____

Patient (or Parent/Legal Guardian) Signature Date

_____

Printed Name

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Speakeasy Therapy Services, LLC

Addendum to Financial Responsibility
Insurance Authorization and Combined Treatment

Medical Insurance and Client Disclosure:

It has come to our attention that certain insurance companies allow a certain amount of visits per calendar year that are combined with other therapies (i.e. SLP, OT, PT, Chiropractic, Pulmonary Rehabilitation, Cardio Rehabilitation, etc...) As such, if your insurance combines visits and you are receiving any of these services elsewhere, then it is your responsibility to notify our office. **"We are not able to track visits from other facilities."** If Speakeasy is not informed that you are receiving services elsewhere, and/or should we provide a service that went over the maximum authorized amount of visits per calendar year due to combined therapies, you agree to pay any amounts for services rendered and any cost to collect those funds.

_____ _____

Patient (or Parent/Legal Guardian) Signature Date

_____

Printed Name

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Speakeasy Therapy Services, LLC

MEDICAL RECORDS OPT IN/OUT AGREEMENT

We are pleased to announce that we are offering to send out via encrypted email, progress notes in April and November so you are aware of the progress being made in therapy/ies.

I would like to **OPT IN** to receiving progress notes in April and November from Speakeasy Therapy.

_____ _____

Patient Name: (PRINT) Date:

_____ _____

Patient OR (SIGNATURE) Email Address to Send Documents
Parent if Patient is a Minor

I choose to **OPT OUT** of receiving progress notes in April and November from Speakeasy Therapy.

_____ _____

Patient Name: (PRINT) Date:

_____

Patient OR (SIGNATURE)
Parent if Patient is a Minor

SPEAKeasy
Speakeasy Therapy Services, LLC

Dear Parent/Legal Guardian,

We understand that navigating custody arrangements can be challenging, and we appreciate the trust you place in our clinic to provide therapy services for your child. As healthcare providers dedicated to your child's well-being, we want to clearly communicate our position regarding custody-related matters.

Our Policy Regarding Custody Matters:

1. Our primary and sole focus is providing quality therapeutic care to your child.

2. We maintain strict neutrality in all custody-related disputes and cannot:
   - Provide testimony about one parent's involvement versus another
   - Document or verify attendance/cancellations for custody purposes
   - Mediate billing or payment disputes between parents
   - Release records to one parent to use against another
   - Participate in custody evaluations or provide opinions about custody arrangements

3. We follow legally binding court orders that are provided to us regarding:
   - Authorization for treatment
   - Access to medical records
   - Communication protocols with each parent
   - Financial responsibility for services

4. To maintain the quality and consistency of care:
   - Both parents must respect our neutral position
   - Communication must remain focused on the child's treatment
   - Administrative matters must be handled according to court orders
   - Regular attendance and cooperation with treatment plans is essential

Please note that if custody disputes begin to interfere with our ability to provide consistent, quality care to your child, we reserve the right to:
   - Pause services until the situation is resolved
   - Discharge your child from our care with appropriate referrals to other providers
   - Require a written agreement from both parents regarding clinic communication protocols

We are committed to your child's progress and development. We appreciate your understanding and cooperation in keeping the focus on your child's therapeutic needs.

Please sign and date:

I have read and understand the above policy regarding custody matters.

Parent/Guardian 1: _____ Date: _____
Parent/Guardian 2: _____ Date: _____

SPEAKeasy
Secondary therapy Services, LLC

TO BE COMPLETED ONLY BY PATIENTS WITH AN INSURANCE DEDUCTIBLE

For those insurance policies that have a deductible $500.00 or less OR co-insurance, please choose from the following options for payment. **All insurance policies that exceed a $500.00 deductible will be required to pay a portion as you go:**

_____ I would like to pay per visit for a portion of the deductible

I understand that my deductible is _____ Individual _____ Met
_____ Family OOP_____ Met

___ I would like the insurance company to be billed first and I will pay the balance after the claim has been processed. (Please note that this could result in a large balance due, and if payment is not collected, the bill will be turned over to a collections agency with additional fees)

Email for balance notifications _____

Patient Name:_____

Parent/Guardian Signature: _____

Date: _____

SPEAK easy
Speechmaty Therapy Services, LLC

TO BE COMPLETED ONLY BY PATIENTS WHO ARE PRIVATE PAY (NOT USING INSURANCE)

Prompt Pay Patients:

Please note that visits need to be paid before services are rendered. Cash or check is preferred. If you pay with a Credit Card a $10.00 fee will be added.

_____ _____

Patient (or Parent/Legal Guardian) Signature Date

_____

Printed Name

SPEAKeasy
Speakeasy Therapy Services, LLC

COVID - 19 Liability Waiver For (Patient Name):

_____

Speakeasy Therapy Services, LLC has put preventive measures in place due to spread or COVID-19. However, given the nature of our evaluation and treatment methods, you may increase your risk of contracting COVID-19. By consenting to treatment today and in any future sessions, you voluntarily assume all risks and agree that you will not hold Speakeasy Therapy Services, LLC or any of its employees, or partners liable for any resulting illness or injury.

To help limit the chance of exposure, we ask that you agree to the following:

1. That in the past 14 days you or anyone in your household have not had a fever, cough, breathing problems, sudden loss of taste or smell, sore throat, sneezing, or muscle aches.

2. That in the past 14 days you or anyone in your household have not traveled abroad, been on a cruise ship, or traveled within the US to an area affected by COVID-19.

3. That you have not been in contact with anyone that has a confirmed case of COVID-19.

In addition, our waiting room is OPEN WITH PRECAUTIONS IN PLACE based on the PHASE/guidelines. Therefore, to be seen, we ask that:

1. Only 1 person will be allowed in the treatment room (if the client is a minor, 1 parent or legal guardian that is not considered to be in a high-risk population can also be in the room). It is recommended that a parent wears a mask if you are going in the back with your child.
2. Please wash your hands before entering the treatment room (we have bathrooms in the front of the clinic).

Signing this document indicates that you understand the risks and agree to abide by these rules to protect yourself and protect the employees of Speakeasy Therapy Services, LLC. Please note that if you cannot abide by these rules, you will not be able to be seen in our clinic, but you can be seen online through our telehealth program. Thank you for your cooperation.

_____ _____

Patient (or Parent/Legal Guardian) Signature Date

_____

Printed Name

SPEAKeasy
Speakeasy Therapy Services, LLC

INFORMED CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my Speech-Language Pathologist/Occupational Therapist/Physical Therapist wishes me to engage in a telehealth consultation.
2. My Speech-Language Pathologist/Occupational Therapist/Physical Therapist explained to me how the video conferencing technology that will be used to affect such a consultation will work during therapy sessions.
3. I understand that a telehealth consultation has potential benefits including easier access to care and convenience of meeting from a location of my choosing.
4. I understand that a telehealth consultation has potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the video conferencing connections are not adequate for the situation.
5. I have had a **direct conversation** with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY Speakeasy Therapy Services, LLC

ZOOM is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and does not require a password. By signing this document, I acknowledge:

1. ZOOM is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither ZOOM or Speakeasy Therapy Services, LLC provides any medical or healthcare services or advice, including, but not limited to, emergency or urgent medical services.
3. The ZOOM Service facilitates video conferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the ZOOM Service or that such information is current, accurate or up-to-date. I will not rely on my healthcare provider to have any of this information in the ZOOM Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient (or Parent/Legal Guardian) Signature Date

_____

Printed Name