



Cancellation Policy

In order to ensure that our clients' needs are met, we have to be able to accommodate many schedules and it is important that we have enough notice on both cancellations and re-scheduling to be able to fill cancelled slots as quickly as possible.

Cancellations must be provided within 24 hours prior to the scheduled session. If cancellation notification is not reported within 24 hours the undersigned will be responsible for a cancellation fee of:

First Incident: \$25

Second Incident: \$50

Third (+) Incident: \$100

When possible, we may re-schedule for another day in a month, provided a slot is available. If there are greater than 3 incidents per 3 month period, the undersigned may lose their current therapy time and be placed at a time that is more convenient, if available; or be placed on a waiting list for the next available time. More than 9 incidents per year may result in dismissal from services. Enforcement of policy is at the sole discretion of S.M.I.L.E.S. administration in that certain circumstances may be excluded from repercussions. Thank you for your cooperation and understanding in this matter.

www.teachtofeed.com

6513 Hamilton Avenue, Cincinnati, OH 45224

513.404.5915



Disclosure Policy

I, _____, _____'s caregiver authorize S.M.I.L.E.S., Inc. to release all pertinent information regarding my child's or my evaluation and/or treatment information to the individual (s), company, or group stated below. I understand that to discontinue authorization, I need to submit a request in writing.

_____ Name	
_____ Street Address	_____ eMail Address
_____ City, State, Zip code	
_____ Phone	_____ Fax

_____ Name	
_____ Street Address	_____ eMail Address
_____ City, State, Zip code	
_____ Phone	_____ Fax



<hr/> Name	
<hr/> Street Address	<hr/> eMail Address
<hr/> City, State, Zip code	
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<hr/> Phone	<hr/> Fax

Patient's Name

Caregiver's Name

Witness

Date

Date



HIPPA Policy

Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

What is This Notice about and Why is it Important?

S.M.I.L.E.S. is required by law to maintain the privacy of patient protected health information and to provide patients with notice of its legal duties and privacy practices regarding protected health information.

We understand that your health information is highly personal and we are committed to safeguarding your privacy. Please read this Notice of Privacy Practices thoroughly. It describes how we may use and disclose your protected health information for:

- treatment
- payment
- health care operations
- other uses and disclosures of such information that the law allows

It also describes your legal right to access and control the use and disclosure of your protected health information.

The rights outlined in this document belong to the patient or the patient's personal representative, who is the patient's parent, legal guardian or any person who has the legal authority to represent the interests of the patient and act on the patient's behalf.

If there is any question as to whether a person is legally qualified to act as a patient's personal representative, please contact S.M.I.L.E.S. directly at the phone number or address listed at the end of this document.

What Does This Notice Cover?

This Notice covers the following types of information:

- Information about your health condition, health care treatment or payment for health care treatment **that could reasonably identify who you are;**
- Information in the possession of any S.M.I.L.E.S. department / division. This applies to all our personnel, volunteers, contractors or anyone working here who might have access to your health information.

We have an Organized Health Care Arrangement Agreement with our Staff which makes this Notice, and the rights and obligations contained herein, applicable to both S.M.I.L.E.S. and to our Staff when they are providing services to patients here.

How We Will Use Your Health Information?

We are permitted to use or disclose to others outside S.M.I.L.E.S., your health information without permission from you for three basic types of activities:

- **Treatment** -- We are permitted to use your health information or disclose it to others outside S.M.I.L.E.S. in order to provide proper medical care to you. This means we can provide your health information to nurses, technicians, doctors, teachers, care providers, allied health professionals, medical students or outside laboratories involved in your care.

For example, the dietitian may need to know your condition if it requires special meals; X-ray and laboratory technicians may need to know your condition to conduct the proper test; or other physicians may need to have your information to advise those providing your care.

In some circumstances we may require you to complete an Authorization form for disclosure of your protected health information to an outside health care provider.

- **Payment** -- We are permitted to use your health information or disclose it to others outside S.M.I.L.E.S. for the care and services you receive.

For example, information about your care or services may be sent to your insurance company, a government insurance program or another company that processes the information and submits it for payment.

We may also provide information to your health plan about treatment you may receive so they may approve or disapprove whether you are covered for that care.

- **Health Care Operations** -- We are permitted to use your health information or disclose it to others outside S.M.I.L.E.S. in order to run the center and ensure high quality care.

For example, we may use your information to review how we provide care to you; we may disclose it to consultants to help us improve how we operate the center; we may disclose it to certain organizations to meet compliance or licensing requirements.

There are situations where we may use your information or disclose it to others outside S.M.I.L.E.S. without your permission, and there are specific circumstances where we must obtain your Authorization prior to using or disclosing your protected health information. They are described below:

- **Appointment Reminders** -- We may use or disclose your health information to send you reminders that you have an appointment for treatment.
- **Treatment Alternatives** -- We may use or disclose your health information to tell you about or recommend possible treatment-related options, activities or alternatives that may be helpful to you.

- **Health-Related Benefits and Services** -- We may use or disclose your health information to tell you about health-related benefits or services that may be of interest to you.
- **Fundraising Activities** -- We may use or disclose your health information to contact you for fundraising activities for S.M.I.L.E.S., by S.M.I.L.E.S., or on our behalf by others.

In our fundraising, we would only disclose certain information, such as your name, address, phone number, and the dates you received treatment or services at our center.

If you do not want to be contacted for fundraising efforts, you must notify us in writing.

- **Patient Directory** -- We may include certain limited information about you in our patient directory while you are a patient at our center, such as your name and address.

This directory information may be disclosed to people who ask for you by name.

During initial consultation you will be given an opportunity to withhold your information from our patient directory.

Any time you wish to remove your information from the patient directory, you must notify us in writing.

- **Individuals Involved in Your Care or Payment for Your Care** -- During times of treatment, we disclose your health information only to you or your personal representative.

We may also disclose your health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

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- **Research** -- Under certain circumstances, we may use and disclose your health information for research purposes.

For example, we may disclose your information to researchers preparing to conduct an investigation to help them look for patients with specific medical conditions.

- **As Required by Law** -- We will disclose your information when required by law.
- **To Avoid a Serious Threat to Health or Safety** -- We may use and disclose your health information to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Marketing** -- We are not permitted to use your information in marketing activities unless you specifically authorize the communication.

Your Rights Regarding Your Health Information

- **Authorization to Use or Disclose Your Information** -- In order for us to use or disclose your information, other than as described above, we will generally need to obtain your written Authorization, which you may revoke at any time to stop any future uses and disclosures.
- **Right to Have Access to Your Information** -- You have the right to look at or have a copy of your health information.

Exceptions include psychotherapy notes; information that may be used in a civil, criminal or administrative action or proceeding; or where prohibited by law.

- **Right to Amend Your Information** -- If you believe the information we have about you is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. The request must be in writing and directed to S.M.I.L.E.S.
- **Right to Request Confidential Information be Provided in a Certain Way** -- You may request that when we send your information to you, we do so in a specific way that is convenient for you, such as only using a work number or by mail. We are not required to follow your request, but we will make every reasonable effort to do so, or find a mutually satisfactory alternative.
- **Right to an Accounting of Our Disclosures of Your Information** -- You also have the right to receive a list of instances where we have disclosed your health information to others for reasons other than treatment, payment or health care operations, or as Authorized by you. The request must be in writing and directed to S.M.I.L.E.S.
- **Right to Limit Our Use or Disclosure of Your Information** -- You may request in writing that we not use or disclose your information for treatment, payment, operations or any other purpose except when specifically authorized by you, when required by law or in emergency circumstances. We will consider your request and respond, but we are not legally required to accept it.

S.M.I.L.E.S. Right to Deny Access to Your Protected Health Information

S.M.I.L.E.S. may deny you access to your protected health information if a licensed health care provider determines that:

- Releasing it could endanger you or someone else
- Your protected health information refers to a third party and releasing it could harm that person; or

- Providing access to a personal representative could harm you or another person

If you are denied access under these circumstances, you may appeal that decision. Under certain circumstances, S.M.I.L.E.S. may deny your request for access to your protected health information without giving you an opportunity to appeal that decision.

S.M.I.L.E.S. Duties Regarding Your Health Information

We are required to protect the privacy of your information, establish policies and procedures that do so, provide this Notice about our privacy practices and follow the practices described in this Notice.

We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this Notice and post the new Notice at our center. You can request a written copy of the most recent version of this Notice at any time or access it on the S.M.I.L.E.S. web site.

How to Make a Complaint about How Your Information is Used

If you believe we have not properly protected your privacy, have violated your privacy rights or you disagree with a decision we made about access to your protected health information, you may contact our center at the address listed below.

You also may send a written complaint to the [US Department of Health and Human Services](#). S.M.I.L.E.S. can provide you with the appropriate address upon request.

How to Get More Information about Our Privacy Practices

To act on any of the information provided in this Notice or for more information about our privacy practices, you may contact S.M.I.L.E.S:

Phone: (513) 404-5915

Email: info@teachtofeed.com

Mailing Address:

S.M.I.L.E.S., Speech-Language Pathology & Education, Inc.

6513 Hamilton Avenue

Cincinnati, OH 45224

This Notice was issued May 1, 2005



Late Return Policy

Parents must return to the session 5 minutes prior to the end of session whether that's, for example, at 5:45pm (end time 5:50pm) or 3:15pm (end time 3:20). Sessions are formally completed at 5:50pm or 3:20pm and premises should be vacated.

Failure to return on time will result in a service charge of \$5.00 for every 7 minutes you are late. Payment of late return fees must be paid on or before the next session. Only 2 late returns are allowed in any 6 month period. More than 2 late returns within 6 months may result in dismissal from services.

The last 5 minutes of the session are to be used to train/educate/inform parent or caregiver. If said person needs to share information then they must return to the session earlier or do so at the beginning of the session. If a session needs to be predominately to answer questions, concerns, review information, request instruction, etc. this is appropriate usage of time. It is of no benefit to the child if the parent has questions or concerns they haven't addressed or tasks they have been assigned and haven't reviewed.

Please respect and be courteous to all other clients and their families. Adhering to the policies will ensure the best possible session for your child, what is hopefully, what everyone desires for their child.

Therapist may request a parent to wait outside due to a behavior issue. This is their call to make, however the parent **must** be waiting. If the therapist has to extend one child's session into another's, then they will make that time up and it will not be forfeited. Please be mindful that every child requires additional time occasionally, even yours. If your child doesn't then be thankful and empathize with the parent whose child requires the extra time. Adhering to the policy will ensure that each child and family receives the best service during their time.

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Payment Policy

Payment for the session is due at the beginning of the session. Payment is accepted in cash or check format. A paid invoice will be provided for your records upon processing the payment.

Payment is accepted at the following intervals:

- each session
- weekly
- bi-weekly
- monthly
- bi-monthly
- quarterly

If multiple payments will be made then payment is required at the beginning of the first session.

If payment is not presented at the beginning of the session, then the session may not be conducted.

If payment is not remitted in a timely manner then retrieval of payment may be turned over to a collection agency.

It is the responsibility of the caregiver to seek reimbursement for costs from their insurance company. Evaluations, progress notes, and necessity statements will be provided upon request for assistance with insurance reimbursement.

Please see our cancellation policy for cancellation fees.



Policy Consent Agreement

I, _____, _____'s caregiver have read, understand, and agree to abide by the following policies set forth by S.M.I.L.E.S., Speech-Language Pathology & Education, Inc:

- Payment Policy
- Cancellation Policy
- Session Policy
- Late Return Policy
- HIPPA Policy
- Disclosure Form
- Video Consent Form

I also understand that any of these policies may be updated at any time and that I will be provided notice, when changes are made.

Patient's Name

Caregiver's Name

Date

Witness

Date



Session Policy

Session time will be established at the time of evaluation or shortly after. All sessions are 50 minute sessions unless otherwise established.

Should a parent not attend the session (as most do not) they are to be back to the therapy room after 45 minutes. For example, if your session is at 3pm you should be back in the therapy room no later than 3:45pm. This will allow time to provide an update on the session and any small tasks to work with at home.

If a parent has information to share or questions to ask this should be done at the beginning of therapy or by returning earlier than 5 minutes before the end of the session. It is important to not be late. Please refer to the updated late return policy included in this packet.

If a patient is late for a session the time missed is forfeited. If a patient is later than 20 minutes then the session may be considered cancelled and is subject to our cancellation policy. Sessions will not be extended to accommodate a late arrival. Please provide yourself with enough travel time to consider traffic delays and ensure maximum time for your session.

Periodically, due to the intense nature of certain sessions, the therapist may at her/his discretion run the session long. If this occurs then the time missed will be awarded. S.M.I.L.E.S., Inc. asks that each family be patient and considerate of the time of others. Understanding is also requested as feeding therapy sessions are very difficult for children.

Caregivers are permitted to run errands or take care of personal business during sessions they have not otherwise been required to be present. It is the caregiver's responsibility to ensure that they are present to pick up their child by 15 to the hour or 15 after the hour depending on start time. If the caregiver is late 3 times in a 6

month period, then they will not be allowed to leave the premises during sessions. If the caregiver is on premise and out in his/her vehicle, it continues to be their responsibility to return to the therapy room at the times stated above. If this becomes an issue then the child may be dismissed from therapy at the sole discretion of S.M.I.L.E.S., Inc.

It is important to vacate the therapy space at 10 minutes to the hour or at 20 minutes after the hour depending on when your session began. It is important that if a parent chooses to leave the premise they must return at the correct time. This is a courtesy to all other families as everyone deserves to have the same consideration. It is for the safety of your child as sanitizing of the space has to happen between each session. It is important to not enter the therapy room no earlier than 5 minutes before your start time and preferably not until it is your time for therapy to ensure that surface areas have dried appropriately from cleaning.

Thank you for your cooperation with this matter. Adhering to the policy will ensure that each child and family receives the best service during their time.



VIDEO TAPING/PHOTOGRAPHY CONSENT FORM

I, _____ give my consent for myself___ or my child____, _____, to be videotaped or photographed by S.M.I.L.E.S., Inc. for any of the following purposes:

Education and/or Consumer Materials

For the purpose of creating educational and/or consumer materials that will describe the nature of S.M.I.L.E.S., Inc., its techniques, services, successes or aid in the understanding of speech, language, swallowing, feeding development; oral sensory motor function, delays or disorders and their treatment.

I understand that the above authorization may be rescinded at any time when presented in writing by myself or other authorized guardian to S.M.I.L.E.S., Inc.

Patient's Name

Caregiver's Name

Date

Witness

Date



Education and Treatment Planning

I understand that under this area that any videotape or photographs will be shown only to other professionals directly involved in the care and treatment of my child; other professionals who may be consulting to assist in a successful treatment outcome; or to provide feedback to my or my child's treatment. All information obtained in these evaluations/therapy sessions will be available to me and the video tape or photographs returned after above stated occurrences. I also understand that neither the videotape nor the photographs will be copied or utilized for any other purpose than stated above.

I understand that the above authorization may be rescinded at any time when presented in writing by myself or other authorized guardian to S.M.I.L.E.S., Inc.

Patient's Name

Caregiver's Name

Date

Witness

Date



General Research and Education

Any evaluation or therapy sessions may be videotaped or photographed or both for general research and educational purposes. They may be collected to aid in the collection of data. All or some of any video tape or photograph may be used in the teaching and/or training of allied professionals (i.e., SLPs, O.T.s, PTs, educators, etc.).

I understand that the above authorization may be rescinded at any time when presented in writing by myself or other authorized guardian to S.M.I.L.E.S., Inc.

Patient's Name

Caregiver's Name

Date

Witness

Date
