OroFacialTx, PLLC
Sue Merino M.A., CCC-SLP, COM
Andrea Butler M.S., CCC-SLP
Orofacial Myofunctional & Speech Therapy
8505 Technology Forest, Ste 503
The Woodlands, TX 77381
(713) 903-2271

Patient Information and Consent

Patient Name_____ M/F_____ DOB _____

Address_____

City_____Zip Code_____

Parent/Guardian Name (if applicable)_____

Relationship_____

Primary email_____

Secondary email_____

Home Phone Number_____Cell phone_____

Primary care physician_____

Physician phone/address_____

Any other specialists?_____

Who referred you to OroFacialTx? _____

Are there any Speech and Language concerns?_____

_____

What do you hope to learn today?_____

_____

What are your favorite activities/hobbies? _____

Where do you attend school or work? _____

Consent to Release/Obtain Protected Health Information / Waiver HIPAA Liability

This seeks authorization for the use and/or disclosure of the specific personally identifiable health information set forth made pursuant to the requirements of 45 CFR§164.508, which states the federal privacy regulations of the Health Insurance Privacy and Accountability Act of 1996 and authorizes OroFacialTx to obtain the personally identifiable health information specifically referenced in this authorization.

- I give my consent to Sue Merino and Andrea Butler with OroFacialTx to use and disclose PHI for treatment of the patient in accordance of the Notice of Privacy Practices.
- I Consent to the use and disclosure of the patient's protected health information to the referring physician/ dentist/orthodontist (Check box ☐ and _____ initial if you do not want your physician/dentist/orthodontist to obtain the information) and any of the healthcare professionals and / or educators listed below. This will be done in accordance of the Notice of Privacy Practices.

- I have received a copy of the Notice of Privacy. Y / N Initials _____

Name of Additional Professionals	Specialty (ENT, Dentist, Ortho, MD, etc.)	Phone

Waiver of HIPAA Liability

Initials _____

- Due to federal guidelines protecting all private patient health information, OroFacialTx has a policy in place that prohibits discussion of all information regarding the patient's assessment, treatment, and care in public areas such as the patient waiting room. All discussion regarding the patient should take place in a private room away from the general public.
- By signing this waiver of HIPAA liability, you as the patient or guardian, is 1) agreeing not to initiate a conversation regarding patient health information in a public setting 2) releasing OroFacialTx from any harm or fault caused by discussions of the private health information in open access areas in our facility such as the waiting room with you as the patient or guardian.
- This waiver will be in place from the date signed below, until such a time that you as the patient or guardian request in writing to OroFacialTx that all discussion take place in a private setting.

Consent to Treatment

Initials_____

- I voluntarily consent to any and all recommended diagnostic procedures and treatment provided by OroFacialTx.
- I am fully aware that orofacial myofunctional therapy, speech, language, and feeding therapy are not an exact science and I am aware that no guarantee has been or can be made as to the results of the treatments at OroFacialTx.
- I will pay in full at time services are rendered.
- We may from time to time take photographs of patients during their course of care with us. We only use these photos for local purposes.
- Do you consent to having you/your child's photograph taken? (•) Yes ( ) No

Communication Preference

Initials _____

Protecting the privacy of your child and your family is extremely important to us, and HIPAA mandates it. While we prefer to give you updates in person after therapy, there will be times when you will want us to send you written information. The HIPAA privacy rule allows us to communicate with you electronically provided that we apply reasonable safeguards when doing so, including encryption, limiting personally identifiable information like full names, etc. The privacy rule does not prohibit the use of unencrypted email and text for treatment related communications, if the patient or the parent of the patient prefers and requests it. Please understand that if you prefer to receive unencrypted emails and texts, then there is a risk that a third party may be able to obtain that information during transmission or while stored on a computer or phone.

For written progress reports, appointment reminders, updates, etc., you have my permission to: (Check all that apply)

- ☐ Send unencrypted emails and I fully understand the risks. (If you do not select this option, we will only send encrypted emails from our HIPAA compliant mail service.)
- ☐ Send unencrypted text messages to my mobile phone and I fully understand the risks. (If you do not select this option, we will not send or reply to any text messages.)
- ☐ I prefer encrypted emails.
- ☐ I prefer that you send written information via USPS or other mail only.

Financial Responsibility and Payment Terms

Initials_____

We are in the business of caring for our patients. That is our passion, but it is a business. So, we hope that you will help us by following these payment terms for speech therapy and orofacial myofunctional therapy.

_____ Agrees to pay OroFacialTx in full at the time services are provided.
Patient or Guardian

- Evaluation Rate - Oral Motor and/or Articulation $ 250.00
- Evaluation Rate - Oral Motor/Articulation/Language $300.00
- Therapy Session Rate - $65.00 /1/2 hour

Cancellation Policy

Initials_____

It is very important to attend regularly scheduled appointments. These scheduled appointments are part of a recommended treatment plan aimed at improving health, function, and overall quality of life. Without regular and consistent attendance, the benefits of therapy will be limited or the overall therapy will take longer.

- Since the time allotted to work with you or your child is very limited, it is imperative that we get right down to therapy as soon as you arrive. We are, of course, interested in a brief update of anything new and relevant since our last treatment session.

- If you feel a need for more discussion, please let us know so that we can save the last several minutes of the session to cover the areas of concern.

- Please try to be as punctual as possible. We hope that any cancellations will be very rare since we have set aside this time especially for your family. Due to the volume of client and limited availability on our caseload, we have found that a cancellation policy is needed. The cancellation policy is as follows:

  Cancellations 24 hours or more in advance – No charge (unless excessive)
  Cancellations less than 24 hours in advance – Charged ½ of session fee (after 3 occurrences)
  Therapy session not cancelled/No Shows –Charged full session fee

  Please feel free to call or email with questions. We look forward to working with you and your family.

My initials on this document indicate that I have read, understand and agree to all consents and policies.

_____

Patient/Guardian Signature Date