cut TO THE SPEECH

Bridging the Gap between Language & Literacy

New Client Handbook

(404) 666-1052 cuttothespeech@gmail.com

Welcome!

Thank you for choosing **Cut to the Speech, LLC** to collaborate with for your child's speech, language and literacy needs. **Cut to the Speech, LLC** offers speech, language, and literacy screenings, evaluations, and remediation. Consultations and a written report are provided with all screenings and evaluations. **Cut to the Speech, LLC** mainly provides in-person services, however, teletherapy is available as a treatment method and for some screenings. The purpose of this handbook is to serve as a reference for the partnership between **Cut to the Speech, LLC** and your scholar.

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Appointments

Please see the chart below for the current available screening, evaluation and remediation times:

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Screenings & Evaluations	9-12am	9-12am	9-12am	9-12am	3-6pm	9-12am
Treatment	1-6pm	1-6pm	1-6pm	1-6pm	X	X

Tardies/Cancellations

In order to provide best results for your scholar, please make it a priority to attend all sessions. Please arrive to all scheduled sessions on time. If you will be tardy, please contact the therapist immediately, however, the therapist cannot guarantee that your scholar will be seen for the entire allotted time.

If you need to reschedule a therapy session, please let the therapist know within **24 hours.** Correspondences made the day of will result in a **Late Cancellation Fee** of 50% of scheduled services. Additionally, if no correspondence is provided the day of service and client does not show for therapy, a full session fee will be charged. All accounts must be paid in full prior to attending future scheduled sessions.

Payments & Fees

Cut to the Speech, LLC accepts payment in the following forms: cash, check, PayPal, Venmo, Cashapp, and Zelle.

Cut to the Speech, LLC does not accept Medicaid, Medicare, or other health insurance plans. However, if requested, you may receive a statement/receipt at the end of each month with applicable billing codes that you can submit to your insurance company for possible reimbursement. ***It is your responsibility to pay your bill promptly*** **and then work with your personal insurance company regarding reimbursement to you.**

Payment is due at the end of each session. If a bundle is selected, payment is due 24 hours prior to the first session. All accounts must be current prior to the clients next scheduled session.

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Please view the chart below for speech, language and reading screenings, evaluations and remediation fees. Additionally, fees for consultations in-person, virtual or via phone conversation have also been added.

	Service	Minutes	Fee
Screenings	Articulation	30	$150
	Language	45	$200
Evaluations	Speech & Language	2-3 hours	$600
	Speech, Language & Reading	Varies per child	$1200
Treatment	Speech	30	$50
	Language	30	$50
		45	$75
		60	$100
	Speech & Language	45	$75
		60	$100
	Reading	45	$100
		60	$125
	Any Combination of Reading w/ Speech and/or Language	60	$140
		90	$175
Consultations		30	$50
		60	$100

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Bundle Option for Treatment

Cut to the Speech, LLC is now offering a bundle option where you pay up front to schedule the amount of sessions requested. Save 10% by enrolling in one of our bundle deals today! :)

Treatment	Goal	Sessions	Bundle Price
	Speech	6 (30 min)	$270
		8 (30 min)	$360
		10 (30 min)	$450
	Language	6 (30 min)	$270
		6 (45 min)	$405
		6 (60 min)	$540
		8 (30 min)	$360
		8 (45 min)	$540
		8 (60 min)	$720
		10 (30 min)	$450
		10 (45 min)	$675
		10 (60 min)	$900
	Speech & Language	6 (45 min)	$405
		6 (60 min)	$540
		8 (45 min)	$540
		8 (60 min)	$720
		10 (45 min)	$675
		10 (60 min)	$900
	Reading	6 (45 min)	$540
		6 (60 min)	$675
		8 (45 min)	$720

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		8 (60 min)	$900
		10 (45 min)	$900
		10 (60 min)	$1,125
	Any Combination of Reading w/ Speech and/or Language	6 (60 min)	$756
		6 (90 min)	$945
		8 (60 min)	$1,008
		8 (90 min)	$1,260
		10 (60 min)	$1,260
		10 (90 min)	$1,575

Screenings & Evaluations

Speech Screening: As children learn more words and produce more speech sounds, they can often produce errors, such as substituting one sound for another, deleting a sound or syllable, or even distorting a sound. The Goldman Fristoe Test of Articulation 3rd Edition and the Clinical Assessment of Articulation & Phonology 2nd Edition are instruments used to assess the client's articulation of speech sounds at the word and sentence level. Additionally, the Oral Speech Mechanism Screening 3rd Edition is administered to assess the client's oral structure (lips, tongue, cheeks, etc. and function. This will allow the clinician to test whether the speech sound errors can be attributed to weaknesses in motor planning, or musculature strength and/or range of motion. All screenings are provided with a verbal consultation and written report.

Language Screening: As children grow, they begin to understand more information and express what they know in a variety of ways. The Clinical Evaluation of Language Fundamentals 5th Edition Screening test is used to screen receptive, expressive and pragmatic/social language abilities. This screening will provide a general overview of language strengths and weaknesses for the client. All screenings are provided with a verbal consultation and written report.

Speech & Language Evaluation: This comprehensive assessment includes the full speech assessment described above, as well as, a full assessment in specific areas of receptive and expressive language domains. The Peabody Picture Vocabulary Test 5th Edition assesses the client's understanding of vocabulary; the Expressive Vocabulary Test 3rd Edition assesses the client's ability to label vocabulary and provide synonyms; the Clinical Evaluation of Language Fundamentals 5th Edition assesses receptive and expressive language in the following areas: sentence comprehension, story comprehension, following directions, word definitions, grammar/syntax, semantics, and language memory. All evaluations are provided with a verbal consultation and written report.

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Speech, Language and Reading Evaluation: This comprehensive assessment includes a complete speech and language evaluation, as well as reading and academic tests. The Clinical Test of Phonological Processing 2nd Edition assesses overall phonological awareness skills, which includes blending, segmenting and manipulating sounds. If the client is age 5.11 or younger, they will be administered the Test of Preschool Early Literacy instead to assess early reading skills. The Woodcock Johnson Test of Achievement 4th Edition assesses cognitive ability, oral language and academic achievement. The Children's Memory Scale assesses the client's memory and how it relates to their overall learning profile. If the client is 10 years or older, they may also be administered the Diagnostic Achievement Battery 4th Edition which assesses multiple academic domains (spoken language, reading, writing and math); the Gray Oral Reading Tests 5th edition which assesses the client's oral reading fluency and comprehension; the Gray Silent Reading Tests which assesses the client's silent reading comprehension ability; the Test of Written Language 4th Edition which assesses the client's overall written language skills. All evaluations are provided with a verbal consultation and written report.

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Treatment

Treatment is provided via two modalities: in-person and virtual. Due to COVID-19, when opting for in-person sessions, it is required for all clients to wear a mask or face shield. If a client is receiving speech therapy, a face shield is more optimal. This will allow the clinician to properly provide prompts and cues to elicit correct speech sound placement. The clinician is required to wear a mask or face shield as well. With both the client and clinician wearing a mask and/or face shield, the risk and exposure to COVID-19 is minimal. If opting for teletherapy, a Zoom link will be provided to log in with. The Zoom ID number and password will not change, unless otherwise noted by the clinician. Additionally, please sign the teletherapy consent form below.

All treatment sessions will end 5 minutes early to allow clinician time to discuss client progress and answer any questions the parent/guardian may have. Please arrive to therapy, whether in-person or virtual, on time.

Teletherapy Consent Form

The American Speech-Language-Hearing Association (ASHA) defines telepractice as "the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation." This means that we are able to provide speech-language therapy services through digital meetings such as secure video conferencing. This is conducted by having the clinician and the child join a computer-based session at the designated therapy time during which they would work on the same treatment goals as in the office.

It is important to know that this service delivery model is supported through the state licensing board and the American Speech-Language-Hearing Association (ASHA). State laws require state-regulated private insurers to cover telepractice on the same basis as in-person services (https://www.asha.org/Advocacy/state/info/GA/Georgia-Telepractice-Requirements/). Nevertheless, it is recommended that you verify this with your insurance company if you receive reimbursement for your speech-language therapy sessions.

By signing this form, I agree that:

I understand that teletherapy includes treatment using interactive audio, video, or data communications.

I understand that teletherapy may involve the communication of my medical information, both orally and visually, through secure video connection.

I understand that while teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.

I understand that either I or my Speech-Language Pathologist can discontinue the teletherapy services if it is felt that this type of service delivery does not benefit my needs or for any other reason.

I understand that the laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

I understand that my clinician currently uses an encrypted session via Zoom to provide teletherapy services. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3)

arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

I have read and understand the information provided above regarding teletherapy and have had the opportunity to discuss it with my Speech-Language Pathologist in order to get my questions answered to my satisfaction.

By signing you agree that you have read, understood, and agree to all the above.

_____	_____
Signature (Legal Guardian)	Date
_____	_____
Print (Legal Guardian)	Client Name

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Privacy Policies

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

"PHI" refers to information in your health record that could identify you.

"Treatment, Payment and Health Care Operations"

-Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.

-Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to assist you in obtaining reimbursement for your health care or to determine eligibility or coverage.

-Health care operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes other than treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Notes. "Notes" are written records I have made about our conversation and therapy during a private, group, joint, or family therapy session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances

Child Abuse – If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.

Adult and Domestic Abuse —If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.

Health Oversight Activities — If I am the subject of an inquiry, I may be required to disclose protected health information regarding you in proceedings before any professional Board.

Judicial and Administrative Proceedings — If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety — If I determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the intended victim.

Worker's Compensation — I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and My Obligations

Patient's Rights

Right to Request Restrictions — You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternate Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are receiving Speech and Language Therapy. On your request, I will send your bills to another address.)

Right to Inspect and Copy —You have the right to inspect or obtain a copy (or both) of PHI in my health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend —You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting — You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy — You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

My Obligations:

I am required by law to:

-Maintain the privacy of PHI;

-Provide you with this notice of my legal duties and privacy practices with respect to PHI and

-Follow the terms of my notice that are currently in effect

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Danielle Moore, The Language Group LLC, at 404 477-9400 , 3756 LaVista Road, Suite 104, Tucker, GA 30084.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to Danielle Moore, , The Language Group LLC, 3756 LaVista Road, Suite 104, Tucker, GA 30084.

You may also send a written complaint to the Secretary of the US Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1, 2019

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will post a copy of the current notice at my office. The notice will contain the effective date on the first page, in the top right hand corner.

Notice of Privacy Practices

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and private practices with respect to protected health information. Your signature below indicates that you received, understand, and agree to **Cut to the Speech, LLC**'s Notice of Privacy Practices.

I have read the Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide **Cut to the Speech, LLC** with my authorization and consent to use and share my protected health information (PHI) for the purposes of treatment, payment, storage, and clinic operations to the extent described in the notice.

_____

Client's Name (Print)

_____

Signature of client or guardian

_____

Authorized Cut to the Speech, LLC Signature

_____

Date

I acknowledge that my completion of the above Signature line with my typed name is the equivalent of my signature for purposes of release and authorization when I return this form electronically.

Authorization to Release and Obtain Information

Cut to the Speech, LLC
3715 Northside Parkway, Building 100, 5th Floor
Atlanta, GA, 30349
Phone: 404-666-1052 | Email: cuttothespeech@gmail.com

I authorize **Cut to the Speech, LLC** to obtain information and/or release information to the following professionals for purposes of assisting with the evaluation, education, course of treatment, therapy and/or remediation for my child:

☐ Diagnostic Information (i.e. evaluation results, reports)

☐ Progress and Observation Reports

☐ Educational Reports

☐ Other: _____

Name & Title of Professional:	Phone Number/Email:
_____	_____
_____	_____
_____	_____

This consent is subject to revocation by the parent or guardian listed below at any time upon receipt of written notice by **Cut to the Speech, LLC**. This consent will expire, if not revoked, 12 months from the authorization date.

_____	_____
Client's Full Name	Date of Birth

_____ _____

Parent or Guardian Name (Print) Parent or Guardian Signature

_____ _____

Relationship to Client Date

_____

Address City State Zip Code

(404) 666-1052 cuttothespeech@gmail.com

Photo Release and Consent Form

Client's Name :_____

I, _____
Print name

Do ☐ Do not ☐

authorize **Cut to the Speech, LLC** to photograph, videotape, or film me/my child for possible use in the Clinic's newsletter, website, social media, advertisements, publicity and promotional materials for educational purposes (such as classes, workshops, or instructional uses), or for any other lawful purpose. I understand that all photos, videos and film footage of me/my child will become property of **Cut to the Speech, LLC.**

I hereby release **Cut to the Speech, LLC** and those acting with its permission and upon its authority, from any liability, responsibility, or claim that may arise by reason of any exercise of the authority granted above. This release and contract will continue until specifically revoked.

I consent to allow **Cut to the Speech, LLC** to use, reproduce, and edit photographs/videos of me/my child during clinic-sponsored activities, learning experiences, and/or for marketing purposes.

_____
Signature of client or guardian

_____
Printed name of client or guardian

_____

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Client Handbook Agreement

I have received, understand, and agree to the information provided in the **Cut to the Speech, LLC** Client Handbook, and understand my rights contained in the handbook.

_____
Client's Name (Print)

_____
Signature of client or guardian

_____
Date

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