



Children's Learning Connection, Inc.

Dear Parent/Caregiver,

Thank you for your interest in using Children's Learning Connection to provide your child's therapy needs. In order to begin the scheduling process, we need a few documents from you in order to complete the insurance verification process.

Attached you will find the following documents:

- Private Insurance Information Form
- Financial Policy Patient Responsibility OR Private Pay Agreement
- Notice of Privacy Practices

Please also include the following:

- A copy of the front AND back of your child's insurance card
- If you have a PPO, and need to start with an evaluation, you will need to obtain a prescription from your child's pediatrician or neurologist requesting the evaluation. *For example, you can ask your child's pediatrician to write "Speech therapy evaluation" on a prescription pad. If your child has a known diagnosis for which the evaluation is being requested (e.g., Chronic Ear Infections), please have your pediatrician include this information on the prescription as well.*
- If you have a PPO and already had a private insurance evaluation completed within the past 6 months, you will need to obtain a prescription from your pediatrician or neurologist a prescription for therapy. This prescription will need to include type of therapy, how many sessions per week, and diagnoses for which therapy is required.

Please complete, sign and return all of these documents to our office as soon as possible. This information may be faxed, mailed, or emailed to us:

Fountain Valley Office
Fax: 714.965.2684
Address: 18350 Mt. Langley #105, Fountain Valley
CA 92708
Email: office@childrenslearningconnection.com

Santa Ana Office
Fax: 714.835.5930
Address: 1651 E. 4th St. #150, Santa Ana, CA 92701
Email: officesa@childrenslearningconnection.com

Upon receipt of these documents, our office will verify coverage, and contact you regarding scheduling your first appointment. ***Please note we will not be able to schedule an appointment until all of these documents have been received and are completely filled out.***

Best Regards,

Children's Learning Connection Staff

Enclosures:

Private Insurance Information Form
Financial Policy Patient Responsibility
Notice of Privacy Practices

☑18350 Mount Langley Street Suite #105, Fountain Valley, CA 92708 Office Tel.: 714.965.2324 Fax: 714.965.2684

E-mail: office@childrenslearningconnection.com

☐1651 E. Fourth Street Suite #150, Santa Ana, CA 92701 Office Tel: 714.835.5587 Fax: 714.835.5930

E-mail: officesa@childrenslearningconnection.com

Website: www.childrenslearningconnection.com

For Office Use only :

Copy of Insurance Card date _____ Referral/RX Authorization date _____ Private Insurance Form Completed, date _____

DATE: _____

PRIVATE INSURANCE INFORMATION

Full Patient Name:

Last First Middle

Address:

Street Apartment Number

City State Zip Code

____/____/____ Sex: Male Female

____ Date of Birth Social Security Number
____ - ____ - ____

Pediatrician Information:

____ (____) ____ - ____ (____) ____ - ____
Pediatrician Name Phone Number Fax Number

Responsible Party Information

Full Legal Name:

Last First Middle

Address:

Street Apartment Number

City State Zip Code

(____) ____ - ____ (____) ____ - ____ ____ - ____ - ____
Home Phone Work Phone Social Security Number

____/____/____ _____
Date of Birth Employer Relationship to Patient

Insurance Information:

____ (____) _____
Insurance Company Phone Number

Policy ID # Group # Group Name

_____/____/____
Policy Holder Name Relationship to Patient Date of Birth

FINANCIAL POLICY & PATIENT RESPONSIBILITY

It is the Patient's Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physicians (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment at the time of the service.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.

It is CLC's responsibility:

- To provide quality therapy services
- To file insurance claims as a courtesy to the patient. A 60 day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.

Cancellation Policy:

Appointments cancelled with less than **18 hours** notice are charged a **\$25** cancellation fee

Financial Policy Acknowledgement:

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage. I am ultimately responsible for the balance on my account for any services rendered.

Patient or Responsible Party Signature _____

Date ____/____/____

Release of Medical Information and Assignment of Benefits:

I authorize the release of medical information necessary for filing health insurance claims for me by CLC. I also authorize my insurance carrier(s) to make payment directly to CLC.

Patient or Responsible Party Signature _____

Date ____/____/____

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF

Children's Learning Connection, Inc.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT
YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET
ACCESS TO THIS INFORMATION.**

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact a Clinical Director at our office: Phone 714.965.2324 Address 18350 Mt. Langley # 105 Fountain Valley, CA 92708

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you services. We may disclose information about you to treatment staff, office staff or other personnel who are involved in taking care of you and your services

For example, your occupational therapist may be treating your child for a developmental condition and may need to know you child has other developmental challenges pertaining speech. The therapist may discuss your child's case with the speech therapist to determine the most appropriate care for your child.

Personnel in our office may not share information with people who do not work in our office without written authorization from you.

For Payment

We may use and disclose health information about you so that the services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan

information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Service Operations

We may use and disclose health information about you in order to run the office and make sure that you and our clients receive quality care. For example, we may use your information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our clients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective. We may also tell you about or recommend possible treatment options or alternatives that may be of interest to you. We may tell you about additional services that may be of interest to you.

Scheduling and Other Routine Office Operations

We may use your information to contact you regarding scheduling. We may use your information to contact you for other routine office operations such as completing required paperwork.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; suspected abuse or neglect, non-accidental physical injuries.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your relative when you bring your relative with you into the treatment room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to a Clinical Director in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about additional treatments not being provided by this office.

We are Not Required to Agree to Your Request

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit a *Request For Restricting Uses and Disclosures and Confidential Communications Form* Information to a Clinical Director.

Right to Request Confidential Communications

You have the right to request that we communicate with you about service matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, please do so in writing to a Clinical Director. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact a Clinical Director.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact a Clinical Director at the office: Phone 714.965.2324 Address 18350 Mt. Langley St. # 105 Fountain Valley CA 92708. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the Notice of Privacy Practices statement of Children’s Learning Connection, Inc.

Client Name _____ Parent Name: _____

Signature _____ Date _____