Kireker Center
for Child Development

SPEECH-LANGUAGE EVALUATION HISTORY FORM

140 E. Ridgewood Avenue
4th Floor North Tower
Paramus, NJ 07652
201-612-1006
201-612-1092 Fax

PATIENT INFORMATION:

Patient Name: ______________________________
Date of Birth: ______________ Age: ______________
Address: ______________________________
Referring Physician: ______________________________
Address: ______________________________
Reason for Referral: ______________________________

SOCIAL:

Siblings: (Names and Ages) ______________________________
____

Special Needs or Concerns: ______________________________
____

Primary language at home: ______________________________
School/Daycare: ______________ Grade: ______________
Any academic difficulties: ______________________________

HEALTH HISTORY:

Any complications during pregnancy? ______________________________
____

Any complications at birth (prematurity, difficulty breathing Rh incompatibility? ______________
____

Any special care at birth? ______________________________
Birth weight: ______________ Any serious illnesses/injuries since birth? ______________
____

Taking medications? ______________________________

DEVELOPMENTAL HISTORY:

At what age did your child perform the following skills?
Lift head __________ Turn over __________ Sit without support __________ Crawl __________
Walk __________ Drink from cup __________ Babbled __________ Say first word __________
Combine words __________ Speak in sentences __________
Describe your child's speech at this time ______________________________
____
____

Any family history of language, learning or hearing difficulties? ______________
____

FEEDING:

Was your child breast-fed? ______________ bottle-fed ______________

Did your child have difficulty sucking? ______________

Did your child lose formula/milk during feedings? ______________

Did he/she spit up frequently? ______________

Does he/she use a pacifier/suck fingers? ______________ Until what age? ______________

Does your child drool? ______________

Does your child drink independently? ______________ Eat independently ______________

Please describe a sample of a favorite dinner meal ______________

____

AUDIOLOGICAL HISTORY:

Do you think there is a hearing problem? ________ Explain ______________

____

Has there ever been a hearing test? ________ When and where? ______________

______________ Results? ______________

Does your child have a history of ear infections or earaches? ______________

Describe treatment for ear infections ______________

BEHAVIOR:

Describe your child's attention ______________

Describe his/her activity level ______________

ADDITIONAL INFORMATION:

Has your child been seen by other professionals or had additional evaluations (e.g. Early Intervention, Developmental Pediatrician)? Please describe: ______________

____

____

____

____

____

Please share any other areas of concern you have regarding your child's development ______________

____

____

____

____

____

VISITS TO THE VALLEY HOSPITAL

KIREKER CENTER FOR CHILD DEVELOPMENT

ARE

HOSPITAL OUTPATIENT VISITS

PLEASE CHECK WITH

YOUR INSURANCE COMPANY

TO BE SURE

YOU **DO NOT**

HAVE A HOSPITAL DEDUCTIBLE

140 East Ridgewood Ave, Paramus, NJ 07652

From Route 17 North, take the ramp toward Oradell. Merge onto E. Firehouse Lane. Turn slight right onto East Ridgewood Avenue. Turn right into first Valley Health System/Mack Cali Centre III entrance.

Follow signs for Pediatric parking.

From Route 17 South, take the East Ridgewood Ave. exit towards Oradell. Turn right into first Valley Health System/Mack Cali Centre III entrance. Follow signs for Pediatric parking.

From Garden State Parkway North, take Exit 165 toward Ridgewood/Oradell. Keep left to take the ramp toward Ridgewood. Merge onto East Ridgewood Avenue. Take exit for From Road. Turn Right onto Mack Centre Drive. Turn right at stop sign onto Winters Avenue. Bear Right. At light, make right onto East Ridgewood Avenue. Turn right into first Valley Health System/Mack Cali Centre III entrance. Follow signs for Pediatric parking.

From Garden State Parkway South, Take Exit 165 toward Ridgewood. Turn Right onto East Ridgewood Avenue. Take exit for From Road. Turn Right onto Mack Centre Drive. Turn Right at stop sign onto Winters Avenue. Bear Right. At light, make Right onto East Ridgewood Avenue. Turn Right into first Valley Health System/Mack Cali Centre III entrance. Follow signs for Pediatric parking.

Parking:

When you come down entrance, turn Left in front of building. Drive straight and turn right after the door.

Pediatric Parking Lot is on your left. There are 30 Spots reserved for us.

Take the North Tower Elevator to the 4th Floor.

Suite #475N

WELCOME TO THE CENTER FOR CHILD DEVELOPMENT

Please circle reason for visit:

Speech Therapy   Physical Therapy   Occupational Therapy   Hearing   Developmental

Today's Date: ______________ Does Birth Sex Match Gender Identity? Y N

Patient's Name: ______________ Gender: ______________

Race: ______________ DOB: ______________

Full Address and Zip: ______________

Home #: ______________ Work #: ______________ Cell #: ______________

Patient's Social Security Number: ______________

Hospital/Place of Birth: ______________

Pediatrician: ______________

Other Referring Doctor: ______________

Parent/Guardian Name: ______________

Primary Insurance: ______________

Secondary Insurance: ______________

Guarantor(Holder of Insurance): ______________ Guarantor's Date of Birth: ______________

Relationship to Patient: ______________ Occupation: ______________

Guarantor's Full Address and Zip: ______________

Guarantor's Social Security Number: ______________

Guarantor's Employer: ______________

Employer's Full Address and Zip: ______________

Employer's Phone Number: ______________

Follow-Up Phone Calls: ______________ ______________

Patient Signature   Date

Permission to Call:	Yes	No	(Please Circle One)
Permission to Leave a Message:	Yes	No	(Please Circle One)
Permission to correspond via email	Yes	No	(Please Circle One)

If yes, please enter Email Address here: ______________

We cannot accept any payment for services at the office. Please be sure to give us your insurance card and driver's License in order to process billing through your insurance company. Thank You!

Disclaimer: Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

THE VALLEY HOSPITAL
Ridgewood, New Jersey

Important Notice to Our Patients About Insurance Coverage

The following insurance information is provided for all of The Valley Hospital inpatients and outpatients receiving _nonemergent or elective procedures,_ *and is intended as a general summary of insurance information where Valley Hospital is in-network or out-of-network with your health plan. This is not intended as specific advice concerning the health benefits you may have. You should contact your health insurer with any questions or for additional information about your specific health benefits.* ***Additional insurance requirements may apply for office visits, emergency, or urgent care which you may receive.***

For Our In-Network Patients: If The Valley Hospital ("we") participates "in-network" with your health plan, we will inform you of this at the time you schedule your appointment or when you arrive for your appointment to the extent that we have this information available to us. If we become aware that our in-network status has changed with your health plan, we will notify you prior to your scheduled appointment or procedure, where we are able to do so.

Physicians may bill separately from the hospital, and you may receive multiple physician bills depending on the care provided. Not all physicians who provide services at The Valley Hospital may be in-network with your health plan. You should contact the physician who is ordering your health care services to determine whether your physician is in-network or out-of-network. You should also find out whether any other physician(s) who are reasonably anticipated to provide services to you also participate in your health plan by contacting the ordering physician or your health insurer for more information. Our employed and contracted physicians may also participate in different or additional health plans, and you can find information about the health plans that they participate in by contacting your physician or health insurer.

- *If you are fully insured or your self-insured health plan has Opted-In to New Jersey out-of-network benefit insurance laws, the following will apply to you:*
  - For any in-network health care you receive from our facility, you will not be expected to pay more than your in-network copayment, deductible, or coinsurance amounts for our facility charges. Unless you voluntarily, specifically and knowingly choose to receive health care services from an out-of-network provider, you will not have any out-of-pocket costs other than the in-network co-payment, deductible or co-insurance amount applicable to an in-network procedure. If you receive a bill from The Valley Hospital for more than these amounts, you should report this to your health plan. You may also report this to the New Jersey Department of Health.
  - If you choose to receive health care services from an out-of-network provider, you may have higher out-of-pocket costs in addition to your copayment, deductible or coinsurance amount. You should contact your health insurer to find out more information about your out-of-network benefits.

For Our Out-of-Network Patients: If we are "out-of-network" with your health plan, we will inform you that we are out-of-network at the time you schedule your appointment or when you arrive for your appointment to the extent that we have this information available to us. You may have higher out-of-pocket costs in addition to your copayment, deductible or coinsurance amounts. What this means is that you could be charged the difference between what your health plan actually pays The Valley Hospital or other health care provider for health care services you receive, and what the actual charge is for those services. You should contact your health insurer to find out more information about your out-of-network and other health benefits.

You should also contact your physician(s) who is ordering your health care services to determine whether your physician(s) is in-network or out-of-network with your health plan. You should also find out whether any other physician(s) who are reasonably anticipated to provide services to you participate in your health insurance plan by contacting the ordering physician or your health insurer for more information.

If your health plan is a self-insured health plan, services you receive may be out-of-network and you may be responsible for more than your co-payment, coinsurance or deductible. Your health plan may not be subject to certain insurance laws affecting out-of-network benefits unless it has voluntarily "Opted-in." You should contact your health insurer or plan sponsor for more information about your out-of-network and other health benefits in advance of services being provided.

I have received a copy of this disclosure for my records.

Print Name | Signature | Date

THE VALLEY HOSPITAL
Ridgewood, New Jersey

AUTHORIZATION FOR THE VALLEY HOSPITAL CENTER FOR CHILD DEVELOPMENT
TO RELEASE PATIENT MEDICAL RECORDS

I, ______________________________ (Name of Patient), born on ______________ (Date of Birth) do hereby consent and authorize The Valley Hospital Center For Child Development to disclose ______________________________ (e.g., identify, diagnosis, prognosis and treatment) information from my medical records and provide it to:

PARENT NAME AND ADDRESS:	PEDIATRICIAN NAME AND ADDRESS:
ATTENTION:	ATTENTION:

The purpose or need for this disclosure is ______________________________

____

I understand that I have the right to revoke this Authorization at any time. I understand that in order to revoke this Authorization, I must do so in writing and present my written revocation to the Privacy Officer at The Valley Hospital, 223 North Van Dien Avenue, Ridgewood, N.J. 07450. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this Authorization will expire on the following date, event, or condition: ______________________________

____

(If you fail to specify an expiration date, event or condition, this authorization will expire in 1 year.)

Please indicate type of record(s) requested and approximate date(s) of service

Inpatient ( ) ______________ Date(s)

Outpatient ( ) ______________ Date(s)

Emergency Room ( ) ______________ Date(s)

Clinic ( ) ______________ Date(s)

Type of Outpatient Test:

____

____
Date

____
Patient's Signature

____
Parent/Legal Guardian or Authorized Representative

____
Witness to Signature(s)

If it is determined by the hospital that your records are protected by Federal or State law and regulations concerning confidentiality of alcohol and drug abuse patient records, the diagnosis and treatment of AIDS, HIV infection or HIV related illness; the following note will be attached to the information sent to the recipient.

NOTE to Recipient of Information: This information has been disclosed to you from records protected by Federal or State confidentiality rules (42 CFR ' 2.1 et seq; N.J.S.A. 26:5c-1 et Seq.) Federal or State rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR ' 2.1 et seq. or N.J.S.A. 25:5c-1, et seq. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal or State rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

THE VALLEY HOSPITAL
Ridgewood, New Jersey

General Informed Consent for Hospital Care Services (Inpatient, Outpatient, & Emergency Services)

1. **CONSENT TO CARE:** I consent to treatment at The Valley Hospital (the "Hospital") as an inpatient and/or outpatient, depending on my medical needs. I have verified that my name and all demographic information on my Admission Form and Hospital identification band are correct. I consent to treatment by the Hospital Medical Staff, and Hospital employees, independent contractors and/or agents. I understand that advanced practice clinicians and physicians who are licensed by law and approved by the Hospital may observe or participate in my care and treatment while in the Hospital inclusive of surgeries and special procedures. I understand that this care may include tests, examinations, anesthesia, and medical and surgical treatments. No guarantees have been made to me about the outcome of my care. I acknowledge the Hospital's authority to dispose of specimens taken for laboratory or pathology examination according to its usual procedures. I understand that the Hospital participates in various health care education programs and that students may participate in my care or treatment. However, I understand that I may decline care provided by students.

2. **NURSING CARE:** I understand that the Hospital will provide general duty nursing care consistent with my medical needs. If I wish to have nursing care beyond what the Hospital deems necessary and appropriate, I may do so at my own cost and must directly arrange for this care.

3. **PATIENT RIGHTS:** I acknowledge that I have been offered a copy of the Hospital Patient Handbook, which includes information regarding Patient Rights, Smoking Cessation Education, Pain Management and a variety of services available to me. I further acknowledge that I have been provided with information on Advance Directives; the New Jersey Department of Health document entitled, "Your Right to Make Health Care Decisions in New Jersey"; and the Hospital's Notice of Privacy Practices.

4. **IMAGES:** I consent to the use of photography or videotaping relating to my medical condition. I understand that any images may be used for my treatment and/or medical education. If used for medical education, at no time will my identity or any information linked to my identity be disclosed. The Hospital will protect the confidentiality of my images in accordance with all applicable federal and state privacy laws.

5. **VACCINATIONS:** I understand that the Hospital may offer certain vaccinations, but that I may decline any vaccination offered to me.

6. **PATIENT PROPERTY:** I understand and agree that the Hospital shall not be liable for the loss of or damage to any of my personal property, including, but not limited to: cell phones, computers, money, jewelry, documents, or other articles of value, unless deposited with the Hospital for safekeeping. I understand that no employee or agent of the Hospital has the authority to increase the Hospital's liability for my personal property.

7. **RELEASE OF INFORMATION:** I understand that the Hospital Medical Staff, as well as Hospital employees, independent contractors and/or agents, may have access to my medical and billing information. I understand that under the law this information may be used and disclosed for treatment, payment and healthcare operations. The information released may include information regarding psychological, psychiatric, HIV and related diagnosis, venereal disease, or drug or alcohol related illness. The Hospital is authorized to disclose all or part of my information as set forth above and in its Notice of Privacy Practices, unless I object in writing.

8. **INSURANCE REQUIREMENTS:** I understand that my commercial health insurer or payor may require that I obtain pre-certification and/or pre-authorization for the services provided to me, and that I am responsible for any charges for health care services that are not pre-certified and/or pre-authorized. I acknowledge that it is my responsibility to understand my insurance coverage requirements, benefits, and limitations.

9. **ASSIGNMENT OF BENEFITS:** I hereby assign to the Hospital and/or physician all rights, title and interests that I may have to receive payment from a health insurer or other payor for services rendered at the Hospital. I authorize the Hospital to appeal on my behalf any denial by my insurer or payor for coverage of such services.

10. **FINANCIAL AGREEMENT:** I understand and agree that I am financially responsible for all balances that are not covered by my health insurance plan or payor. I agree to make prompt payment to the Hospital for any and all charges not paid by my health insurer or other payor, to the fullest extent permitted by law.

THE VALLEY HOSPITAL
Ridgewood, New Jersey

General Informed Consent for Hospital Care Services (Inpatient, Outpatient, & Emergency Services)

Rev. 09/18

IMPORTANT NOTICE REGARDING MEDICAL PROVIDERS

I understand that the physicians or other practitioners involved in my care may NOT be Hospital employees or agents, but instead independent contractors granted the privilege to use the Hospital's facilities. Independent contractors are responsible for their own actions and the Hospital is not liable for their acts or omissions. I understand that any physician or other practitioner who treats me at the Hospital may not participate in or accept the same insurance or health care plans as the Hospital, so I may be balance billed. I understand that professional services fees are billed separately from Hospital charges, and that I am responsible for payment of both Hospital charges and professional services fees not covered by my health insurer or other payor.

MEDICARE BENEFICIARY (IF APPLICABLE)

☐ I am a Medicare Beneficiary and have received a copy of the notice, "AN IMPORTANT MESSAGE FROM MEDICARE." My signature only acknowledges my receipt of this message from the Hospital and does not waive any of my rights.
I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by or in the Hospital, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits for related services.

ADVANCE DIRECTIVES AND/OR POLST (PATIENTS 18 OR OVER ONLY)

I have an **Advance Directive and/or Medical Power of Attorney** ☐ YES ☐ NO ☐ UNKNOWN
If YES, please check one:
☐ A new copy is provided for the medical record.
☐ A copy is on file from a prior admission or treatment and should be used unless modified or revoked.
☐ A copy will be provided for the medical record.

I have **Practitioner Orders for Life-Sustaining Treatment.** ☐ YES ☐ NO ☐ UNKNOWN
If YES, please check one:
☐ A new copy is provided for the medical record.
☐ A copy is on file from a prior admission or treatment and should be used unless modified or revoked.
☐ A copy will be provided for the medical record.

PATIENT DIRECTORY (INPATIENT ONLY)

☐ **UNRESTRICTED:** I want my name and location to be included in the Patient Directory during my stay in the Hospital, and I understand that this information will be available to those who ask for me by name, such as relatives and friends. I also want my religious and congregational affiliation, if any, to be included and understand that this information may be given to clergy or representatives of my congregation.

☐ **RESTRICTED:** I want to restrict my information and/or visitors as follows **(please check all that apply):**
- ☐ I want to be listed in the Patient Directory as "Confidential" and understand that this designation means that **ALL** visitors and callers will be told that the Hospital has **NO** information about me and that **NO** visitor passes will be issued.
- ☐ I do not want my religious or congregational affiliation shared with outside clergy or my congregation.
- ☐ I want to limit my visitors and the names of any restricted visitors have been given to Hospital Security.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS GENERAL CONSENT TO HOSPITAL CARE SERVICES. ANY QUESTIONS I HAD WERE ANSWERED TO MY SATISFACTION, AND I AM THE PATIENT OR AM DULY AUTHORIZED BY THE PATIENT TO SIGN AND ACCEPT THE TERMS OF THIS CONSENT.

Signature of Patient or Patient's Authorized Representative ____________ Date ____________ Time ____________

Only if Patient is unable to consent, complete the following:

Name of Patient's Authorized Representative ____________ Relationship to Patient ____________

Reason Patient Cannot Consent ____________

Name of Witness ____________ Signature of Witness ____________

THE VALLEY HOSPITAL
Ridgewood, New Jersey

Authorization For Release Of Patient Records And Information, Agreement To Pay For Services And Assignment Of Reimbursement Benefits, Insurance Authorization

I. RELEASE OF PATIENT RECORDS AND INFORMATION

In order to allow the Hospital and Hospital-based physicians providing services to obtain reimbursement, I authorize and consent to the disclosure of information or parts of my Medical Record (even if it includes diagnoses and treatment of AIDS, HIV Infection or HIV related illness and treatment of alcohol abuse and/or drug abuse). These disclosures may be made during the course of my treatment at the Hospital and after treatment. Disclosure may be made to any person or corporation which maybe liable to the Hospital or Hospital-based physicians for all or part of their charges. Disclosures may be made to me, my spouse, hospital or medical service companies, my employer, HMOs, insurance companies, workers' compensation carriers, welfare fund or government agencies. Disclosures may include, but are not limited to, my identity, diagnosis, prognosis and/or treatment or procedures performed and costs, charges and expenses incurred.

I authorize and consent to the Hospital and its representatives appealing, on my behalf, any utilization management determination made by my HMO, insurance company or a designated review agency, which results in a denial, termination, or other limitation of covered health care services.

I authorize the Hospital and its representatives, during the course of my hospital stay, to discuss with and/or provide access to my medical records and information to any person or organization to facilitate the provision of post hospital care, treatment or services.

I understand that this consent is revocable at any time, except to the extent that action has been taken in reliance upon this authorization. If not revoked, this consent will remain in force for a reasonable time in order to carry out the purposes for which it is given.

II. AGREEMENT TO PAY FOR SERVICES AND ASSIGNMENT OF REIMBURSEMENT BENEFITS

In consideration of the services rendered to me at or by The Valley Hospital, I hereby agree to pay the Hospital and all Hospital-based physicians/providers providing services to me, the entire amount due for all services I receive. I hereby assign insurance benefits directly to the Hospital and all Hospital-based physicians providing services to me which otherwise may be payable to me. I further understand that any recovery of a monetary settlement resulting from my present illness or injury from insurance, litigation or otherwise will first be applied toward payment of the cost of my Hospital care. If the amount of such settlement received by the Hospital is less than the value of its services, as set forth in the bill(s) rendered to me, I will pay the difference between the amount of such settlement and the total bill for Hospital services. I agree to pay the Hospital for services which I choose to receive even though my health insurer or payor has not, through its review process, approved the provision of such services. I agree to pay the Hospital for all non-covered charges, including, but not limited to, telephone, television and any private room differential.

III. INSURANCE AUTHORIZATION

I understand that my Health Insurance Company or payor may require me or my doctor to obtain precertification, admission notification review or a second opinion prior to obtaining Hospital services, Emergency Room treatment and/or admission. I understand that it is my responsibility to obtain all such authorizations and that failure to do so may result in a reduction, denial, or other limitation of covered health care services for which I may be liable. I also understand that the services must be, as defined by my insurance company, medically appropriate or necessary to be considered for payment.

I also understand that my insurance will cover only the dependents listed under my insurance policy. Newborns or dependents **must be added** to the insurance policy to be covered (time frame is dependent on your insurance carrier). You must call your insurance to confirm the dependent coverage.

IV. ADDITIONAL BILLS

In addition to your bill from The Valley Hospital, you may receive other bills for services rendered during your inpatient stay or outpatient/Same Day service for an interpretation of an exam or for a physician professional component. These bills will be mailed to you separately and are not part of the charges incurred for your hospital stay or outpatient service.

I certify that I have read and that I understand this authorization; that any questions I had about this authorization were satisfactorily answered. I further certify that I am the patient or am duly authorized by the patient to act on the patient's behalf to sign this document and accept its terms. This Financial Consent will remain in effect for the duration of my treatment for this hospital stay or outpatient service.

Date: ______________ Time: ________

____
Patient's or Authorized Representative Signature

Patient is unable to consent because: ______________________

____

____
Witness to Signature(s)

____
Name of Person Signing/Relationship to Patient (Print in Caps)

I have received a copy of the Valley Hospital's Notice of Privacy Practices and Important Insurance Fact Sheet:
Initials: ____________ Date: ________________

If it is determined by the Hospital that your records are protected by Federal or State law and regulations concerning confidentiality of alcohol and drug abuse patient records, the diagnosis and treatment of AIDS, HIV infection or HIV related illness, the following note will be attached to the information sent to the recipient.

NOTE to Recipient of Information: This information has been disclosed to you from records protected by Federal or State confidentiality rules (42 CFR §2.1 et seq.; N.J.S.A. 25:5C-1, et seq.). Federal or State rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR §2.1 et seq. or N.J.S.A. 25:5C-1, et.seq. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal or State rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

THIS AUTHORIZATION IS RETAINED BY THE BUSINESS OFFICE

THE VALLEY HOSPITAL
KIREKER CENTER FOR CHILD DEVELOPMENT
INSURANCE GUIDELINES

1. **PLEASE NOTE:** Visits to the Kireker Center for Child Development are hospital outpatient visits. If your insurance plan has a hospital deductible it will apply to this visit.

2. If your insurance plan requires a referral it is your responsibility to obtain this from your pediatrician. Also, you should know that a referral form from your physician is not a definite guarantee that therapy will be covered.

3. **You are responsible for keeping track of the number of visits and/or the expiration date of your approved visits.**

4. It is strongly suggested that you call your insurance company and verify your benefits for the service requested, including the initial evaluation. They usually require codes for procedure (CPT) and diagnosis (ICD-9). We will use our best effort to provide the necessary codes.

5. Even if you are told by the insurance company that you have coverage, services, including the initial evaluation, can be denied when one or more chronic diagnoses are present because coverage for these diagnoses may be excluded from your plan. In the event your insurer denies a service as non-covered, the service will be billed directly to you.

6. We will attempt to get prior authorization from your insurance company for the visits we are recommending using the diagnostic codes provided at the time of the evaluation. **We can only authorize the number of visits allowed under your plan.** If your child requires additional visits, we will let you know; however, **you are responsible for obtaining any authorizations for additional visits that are outside the scope of your particular benefit plan.** We will provide you with the treatment/clinical documentation but any additional authorizations are your responsibility.

7. We will only hold a treatment slot open for two weeks. In the event you are unable to obtain additional authorizations within this two week time period, your child will be placed back on the waiting list and will be scheduled at the earliest available opening.

8. In the event your insurance company denies authorizations for services for any reason and you choose to receive services, you are responsible for payment and will be billed directly.

9. Your benefit plan may not require prior authorization. However, in the event your insurer retrospectively determines that the services are not medically necessary under the terms of your benefit plan or are in any way outside the scope of your benefit plan, you will be billed directly for any denied services.

10. Please be advised that your insurance company may include the service (i.e. speech therapy) in their coverage **BUT** they may only cover this service if it is deemed medically necessary (i.e. result of stroke, accident or congenital anomaly) and only if the underlying diagnosis is included for coverage under your plan.

ParentSignature______________________________ Date__________________

KIREKER CENTER
FOR CHILD DEVELOPMENT

I have received a copy of the Kireker Center for Child Development Handbook and understand my responsibility to discuss any concerns/questions regarding my child's treatment.

Please pay particular attention to our attendance policy.

If you are unable to keep an appointment, please call 201-612-1006 in advance to cancel. If two (2) consecutive appointments are missed without prior cancellation OR if 50% or more visits are missed in a two (2) month period, therapy will be discontinued. We reserve the right to charge for No Shows. Be advised that your insurance company will not reimburse for any No Show appointments.

As a reminder, children cannot be left unattended in the waiting room. A parent or designee must remain in the Center at all times while the child is receiving services.

Please sign below to indicate that you have received this Handbook.

____

Child's Full Name

____________________________________ _________________

Parent/Guardian Signature Date

Please Note:
Handbook contains guidelines for obtaining a free evaluation through the State of New Jersey Early Intervention Program.