CY-HOPE COUNSELING
Professional Counseling & Speech Services

12715 Telge Rd
Cypress, TX 77429
713.466.1360
www.cy-hopecounseling.org

Qualifications

We are pleased you have selected Cy-Hope and Wendy Wiseman, M.S., CCC-SLP for your speech and language services. This document is designed to inform you about our background and to ensure that you understand our professional relationship.

Wendy holds a Bachelor's degree in Communication Disorders from The University of Houston and a Master's degree in Speech Language Pathology from Texas Woman's University. She has been working with children and their families for 20 years. For 13 years, Wendy has held certification with the American Speech-Language-Hearing Association as well as Texas state licensure. For many years, Wendy had the opportunity to provide speech and language intervention for elementary and preschool-aged children as a classroom teacher in a private school setting, The Parish School, serving children with language and learning differences. Most recently Wendy provided speech and language therapy services for preschool through fifth grade students at elementary schools in the Cypress Fairbanks Independent School District. She has a passion for engaging with children and their families, serving as a positive influence in the journey through speech, language and learning intervention. Wendy believes whole-heartedly in the benefits of early identification and intervention. She also strives to help children of all ages achieve increased self-esteem and their most effective communication skills. Wendy has a wide range of experience working with children who have: Developmental Delays, Expressive/Receptive Language Disorders, Pragmatic/Social Language Disorders, Childhood Apraxia of Speech, Articulation/Phonological Disorders, Autism Spectrum Disorders, Attention and Memory Disorders, and Fluency (stuttering) Disorders.

Referrals

If you become dissatisfied with Wendy's services at any time, please let her know. It is Wendy's obligation to provide a list of other professionals that may be of more help to you.

Center Policies

It is Cy-Hope Counseling and Speech Therapy's policy that any child age 12 and younger have a parent or adult guardian remain onsite for the entire speech evaluation or therapy session.

If a client cancels and/or does not show to 3 consecutive appointments, Cy-Hope Counseling and Speech Therapy reserves the right to change the client's therapist and/or appointment time.

Records and Confidentiality

The law protects the privacy of all information obtained during the counseling process. In most situations, Cy-Hope Counseling and Speech Therapy can only release information about a client if the client, a parent, or guardian signs a written Release of Information. A Release of Information is specific to an individual, another professional, school or agency. You should also be aware that, pursuant to Texas law, any test data can only be released to trained professionals.

There are some situations where Cy-Hope Counseling and Speech Therapy is permitted or required to disclose information without either a consent or a Release of Information.

These include:

1. If a client is involved in a court proceeding and a request is made for information concerning the client. Cy-Hope Counseling and Speech Therapy cannot provide any information without the client's or client's legal representative's written authorization. However, if Cy-Hope Counseling and Speech Therapy receives a court order, Cy-Hope Counseling and Speech Therapy may disclose information without the client's consent or

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authorization. If the client is involved in or contemplating litigation, the client should consult his/her attorney to determine whether a court would likely order Cy-Hope Counseling and Speech Therapy to disclose information.

2. If the client's records are subpoenaed as part of a criminal investigation, Cy-Hope Counseling and Speech Therapy must disclose the client's records without the client's consent or authorization.
3. If a client files a complaint or lawsuit against Cy-Hope Counseling and Speech Therapy, Cy-Hope Counseling and Speech Therapy may disclose relevant information regarding the client without the client's consent or authorization in order to defend itself.

There are some situations in which Cy-Hope Counseling and Speech Therapy is legally obligated to take action. These include:

1. If Cy-Hope Counseling and Speech Therapy has cause to believe a child under age 18 has been or is at risk to be abused or neglected (e.g. physical injury, a substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct) or that a child is a victim of a sexual offense, the law requires Cy-Hope Counseling and Speech Therapy to make a report to the appropriate governmental agency. This is usually the Texas Department of Family and Protective Services. Once such a report is filed, Cy-Hope Counseling and Speech Therapy may be required to provide additional information to this agency.
2. If during the course of speech therapy services Cy-Hope Counseling and Speech Therapy learns that a client has been sexually abused or exploited by a mental health professional, state law requires Cy-Hope Counseling and Speech Therapy to report this information to law enforcement and the professional's licensing board.
3. If Cy-Hope Counseling and Speech Therapy determines that there is a probability that the client is in imminent danger of harming himself/herself or others, Cy-Hope Counseling and Speech Therapy may contact family members or others (e.g. medical, mental health, or law enforcement personnel) to provide protection for the threatened individuals.

Wendy will keep a written record of speech sessions. Some sessions may be audio and/or video-taped. This is for the protection of both parties involved and will be kept confidential. It is Wendy's intention to render services in a professional manner consistent with the accepted standards of practice. Please note that after 30 days without contact between us, Cy-Hope Counseling and Speech Therapy will no longer consider you a client. Should you wish to return for services, you will begin the intake process again.

Individual sessions typically run 30 – 50 minutes. Your consideration in arriving **on time for your scheduled appointment is greatly appreciated**. In the event of a cancellation, **24 hours prior notice is necessary** to avoid being charged for the session. Fees for various services are noted on the attached *Fee Schedule*. Payment is due at the time service is provided.

May we acknowledge by correspondence the person or agency who referred you? **Yes** **No**

Who may we thank for referring you to Cy-Hope Counseling and Speech Therapy?

_____

Please sign and date this form showing that you agree to the terms above.

_____ _____

Client/Parent/Guardian Signature Date Clinician Signature Date

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Patient Information Record

Patient Name (first, middle, last): _____

Date of Birth: _____ /_____ /_____ Sex: Male Female Age: _____

Race:_____ Ethnicity:_____ Language Preferred:_____

Grade, if applicable:_____ School, if applicable: _____

Home Street Address: _____City: _____St: _____ Zip: _____

Primary Phone: _____ Cell Phone: _____ Texting OK? Yes No

Primary Email: _____

(If client is a minor, please fill in parent information below.)

Parent Name:
_____

Address: _____

_____
City State Zip

Email: _____

Primary Phone: _____

Cell Phone: _____

Texting OK? **Yes** **No**

Parent Name:
_____

Address: _____

_____
City State Zip

Email: _____

Primary Phone: _____

Cell Phone: _____

Texting OK? **Yes** **No**

Party Responsible for billing:

Name: _____ Relationship to patient: _____

Social Security #: _____-_____-_____ Driver's License #: _____

I understand that I am responsible for all amounts due at the time of service. I understand Cy-Hope Counseling does not file insurance on my behalf. However, I can request to be provided with an itemized statement in order to file for insurance reimbursement on my own.

_____
Signature

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment, and follow-up among the multiple healthcare providers who may be involved in that treatment directly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:
Relationship to patient:
Signature:
Date:

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date:	Initials:	Reason:

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Parental Consent for Treatment/Evaluation

(For persons under 18 years)

_____ has my/our permission to participate in the speech therapy services
(Child's name)
provided by Wendy Wiseman, M.S., CCC-SLP. We understand that all materials (interview information, test scores, audio/video tapes, and other personal data) will remain confidential and will not be released to any other agency or person without my/our written consent. My/our written consent to allow the above-named person to participate in these therapy services does not waive any of my/our legal rights.

_____ _____
Parent/Guardian Address

_____ _____
Parent/Guardian City/State/Zip Code

_____ _____
Date (Area Code) Phone Number

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Consent for Release of Confidential Patient Information

In most cases, we feel it is to your advantage that we work with our client's doctor(s) or others who may have a role in our client's care. If the client is a child, it is often helpful for us to have contact with teachers, speech-language pathologists, school counselors and/or principals. To communicate with these people about you and/or your child, we need your permission. Please sign the release of information below, which allows us to discuss you and/or your child with these people, and/or mail letters/reports to them.

CLIENT NAME: _____ CLIENT DATE OF BIRTH:_____

I, _____ (print name) authorize the following provider and/or organization to disclose, and/or use, the following confidential patient information to the designated person and/or organization for the purpose(s) listed below.

Information disclosed by:	Information received by:
Cy-Hope Counseling and Speech Therapy (name of provider/organization) 12715 Telge Road (address) Cypress, Texas, 77429 (city, state, zip) 713-466-1360 1-832-218-1332 (phone number) (fax number)	_____ (name of provider/organization) _____ (address) _____ (city, state, zip) _____ _____ (phone number) (fax number)
How would you like the information sent? _____ To be mailed or emailed _____ To be picked up by: _____ _____ To be sent via fax	For the purpose of: (please state) This request, and authorization applies to only the following protected health information: _____ INITIAL INTAKE _____ PROGRESS NOTES/SUMMARY _____ SPEECH/LANGUAGE REPORTS/EVALUATIONS _____ PARENT CONFERENCE INFORMATION _____ TREATMENT PROGRESS _____ OTHER: _____

I understand that I may revoke this consent at any time (except to the extent that disclosure has already occurred in reliance upon this consent) by sending a written revocation to the organization designated above.
Otherwise, this authorization is given:

_____ During the following time period or dates: _____ OR

_____ Until Termination of Speech Therapy

I understand any information disclosed by this authorization to any person/organization not a health care provider covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.

To the receiving party of this information: this information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed consent of the patient is prohibited. These records may be protected by federal regulation (42 CFR part 2).

_____ _____
(Patient's Signature) or (Parent/Guardian or Authorized Representative) (Date)

_____ _____
(Witness Signature) (Date)

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Speech Language Pathology Services - Fee Schedule

(services provided by Speech Language Pathologist - SLP)

Initial Intake (with Parent and Child)

- meeting to review parent packet, sign consent forms, review previous evaluation (if applicable), review client's medical/developmental history, client's strengths, and areas of concern, establish rapport
  $75 (30 minutes)
  $125 (50-60 minutes)

Speech and Language Evaluation

- assessment of client's communication skills both formally and informally, virtual parent meeting to review report summary and recommendations, written report completed and provided
  $400 (approximately 2 hours)
  ** Initial Intake fee may be applied toward the full evaluation fee when the evaluation is scheduled within 30 days of the initial intake. **

Speech and Language Individual Therapy Sessions

- therapy provided to target individualized speech and language needs of client
  $75 (per 30 min session, one time/week)
  $65 (per 30 min session, two or more times/week)

  $100 (per 45 min session, one time/week)
  $90 (per 45 min session, two or more times/week)

  $125 (per 60 min session, one time/week)
  $115 (per 60 min session, two or more times/week)

Parent Conference

- meeting or phone call scheduled by parent and SLP to discuss client progress, concerns, etc.
  $125 (50-60 minutes)
  $75 (30 minutes)

Professional Consultation

- meeting or phone call scheduled by SLP, per request and consent of parent, to discuss client, attend outside meetings, etc. with schools or other agencies
  $125 (50-60 minutes)
  $75 (30 minutes)

Preparation of Documents

- documents prepared by SLP, per request and consent of parent, for schools or other agencies
  $125 (50-60 minutes)
  $75 (30 minutes)

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Billing Policy

1. Appointments must be cancelled 24 hours in advance or client will be charged the full session fee. Payment for sessions cancelled without notice is expected prior to scheduling the next appointment.
2. Fees are to be paid at the time services are rendered. Exact cash, check, and all major credit cards are accepted.
3. An encounter form, verifying client's payment for session, is provided should client wish to file an insurance claim.
4. The client or responsible party is ultimately responsible for any fee for services rendered.

I, the undersigned, have read and do agree to the above fee and billing policies of this office.

_____

Signature (Responsible Party) Date

_____

Signature (Clinician) Date

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Court Related Fees and Services

- Court testimony costs begin at $250.00 an hour with a minimum charge of three hours. A retainer of $750.00 is due before any court related services are provided.
- Travel is billed at .50/mile. Failure to provide the specific fees as described constitutes a release from the requested court appearance.
- It is required that a minimum of 36-hour notice be given if the testimony is not required, otherwise the entire retainer is forfeited. If proper notice is given, the retainer will be refunded.
- Additional services related to court preparation including all correspondence with attorneys or other service providers via phone, email or letter, documentation review and/or documentation preparation are also billed at $250.00 per hour, rounded to the nearest 15-minute increment.
- In cases where a therapist is being contracted to work with a child in a divorce/custody case, a certified copy of the temporary orders or divorce decree must be provided prior to the therapist beginning treatment.

I understand that my fee will be $125/hour, $75/half-hour for each speech therapy session and $250/hour for court related services.

_____ _____
Signature (Responsible Party) Date

_____ _____
Signature (Witness) Date

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Credit Card Authorization

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modifications. This form will be securely stored in your clinical file and may be updated upon request at any time.
In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time you will be charged a full session fee. If a check is returned unpaid, you will be charged the full session fee. An additional $25 fee will be assessed for 1) returned checks, and 2) inaccurately disputed claims/charge backs.

Please list ALL clients and their date of birth to be authorized to charge session fees on the card listed below:

Client name/s and date of birth: _____

Address: _____

City: _____ St: _____ Zip: _____

Home Phone: _____Mobile Number: _____

Email: _____

I, _____, hereby authorize Cy-Hope Counseling and Speech Therapy to bill my credit card at the usual fee for professional services including all the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Telephone, email, or Skype consultations
- Appointments that I have cancelled with less than 24 hours' notice
- Returned checks
- Fees not covered by insurance or insurance payments make to patient rather than provider

Please indicate the form of payment you wish to use for any services rendered through this practice. Fees will be deducted from the designated account at the time services are rendered.
Cardholder Information: Please indicate the name and address associated with the credit or debit card you wish to use.

Name on card: _____

Address only needed if CC billing address is different from address listed above.

Billing Address: _____

City: _____ St: _____ Zip: _____

By signing this form, I am authorizing Cy-Hope Counseling and Speech Therapy to bill my credit card or debit card ending in _____ (provide last 4 digits of the card) at the usual fee for professional services. I will not dispute charges ("Charge Backs") for sessions I have received or appointments I have missed according to the above policy.

_____ _____
Cardholder signature Date

_____
Print Name

Card Type (circle one): **Visa** **MasterCard** **Discover** **AmEx** Expiration Date: _____

Card #: _____ Security Code (3-digit code): _____