DONNA GLASER ORLOFF, MA, CCC/SLP

Speech and Language Pathologist

175 East 79th Street Ste 1A
New York, NY 10075
Telephone: (212) 794-3269
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WELCOME TO THE FULL POTENTIAL RESOURCE CENTER

I would like to welcome you to the Full Potential Resource Center. Please note that in order to maximize your experience, both new and existing clients will be receiving several documents explaining the services that we offer as well as our office policies. We would appreciate your providing any requested information, even if it has been provided in past years, and returning the designated forms to our office within a week of receiving them.

All clients' parents/legal guardians must sign the "*Consent for Treatment and Authorization to Release Information"* as well as the "*Acknowledgement of Receipt of Full Potential Resource Center Office and Privacy Policies."*

We suggest that you keep a copy of all documents for your records and future reference.

As always, I remain available for any questions or concerns and I thank you for your cooperation.

Donna G. Orloff and Associates

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DATE____________________

CLIENT CONFIDENTIAL INFORMATION

CLIENT'S **LAST NAME: ____**

CLIENT'S **FIRST NAME: ____**

STREET: ____ APT.# ____________

CITY: ____________________________ STATE: __________ ZIP: _______________

HOME PHONE: _________________E-MAIL ADDRESS: _______________________

MOTHER'S NAME(s):___________________ CELL PHONE: ____________________

FATHER'S PHONE(s): __________________ CELL PHONE: ____________________

PHYSICIAN: _________________________ PHYSICIAN TEL#:__________________

REFERRED BY: ____

DATE OF BIRTH: ____

SCHOOL(s) ATTENDED: _______________________________GRADE:___________

PERSON(s) RESPONSIBLE FOR BILL:_______________________________________

ALLERGIES: ____

REASON FOR REFERRAL: ____

____

Does your child currently receive any other services (i.e., occupational therapy, speech/language; psychotherapy, academic tutoring, SEIT services? Yes_____ No_____
If yes, please list the service type, provider, and telephone number:

Service Type	Provider Name	Telephone Number
_______________	___________________________	_____________________
_______________	___________________________	_____________________

Does your child receive special education services or have an individualized education plan (IEP)?
Yes_____________ No_____________

Are there any special circumstances relating to your child or family of which we should be aware?
____

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FULL POTENTIAL RESOURCE CENTER OFFICE POLICIES

I would like to take this opportunity to formally welcome you to the **Full Potential Resource Center**. I am looking forward to a professional, productive relationship devoted to the speech and language needs of your child. Although the focus of the **Full Potential Resource Center** is *individualized therapy*, it is necessary for you to be aware of applicable office policies with regard to our working together in the future.

SCHEDULING

We will always try to be as flexible as possible in **scheduling**, but this is a busy office with appointments scheduled well in advance. We therefore ask for your help and understanding in both making and canceling appointments.

1) Prior to the beginning of each academic year you will receive a scheduling questionnaire. Your prompt response to this is not only appreciated, but also necessary for you to secure a therapy time that is appropriate for your child.
2) Once your child has been assigned a time with a therapist, that time is his/her appointment and is no longer available to anyone else. Accordingly, **cancellations** less than 24 hours prior to your child's visit for anything other than sudden illness or an emergency will be billed to you.
3) As therapists see children on a scheduled basis, it is important that your child be on time for the appointment and remains supervised in the waiting room until they are called into the treatment room.

PAYMENT

Fees will be established prior to the initiation of therapy. The **Full Potential Resource Center** does **NOT** participate in any health care plans. You will receive a bill on a timely basis at the beginning of each month which will be complete and have all the information that your insurance company requires. In addition, we will work with you to obtain the full reimbursement to which you are entitled under the terms of your policy.

However, *payment for therapy services* is not contingent on the timing or amount of your insurance reimbursement, and is your obligation. Accordingly, upon receipt of your invoice we ask that you submit **payment in full** for the prior month's services and any outstanding balance as promptly as possible. We very much appreciate your cooperation and understanding with regard to this policy.

Payment for *evaluations* is expected at the time that services are rendered and no report will be released until payment in full is received.

Please note that there is NO CHARGE for *telephone conferences* with parents, teachers, physicians or tutors as these are essential to a well-designed therapeutic program. School visits and extended in-person office conferences will be billed at the regular session rate.

PRIVACY AND CONFIDENTIALITY

Protecting your privacy and that of your child is of the utmost importance and a responsibility that the Full Potential Resource Center takes very seriously. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our practices and policies.

During the course of evaluation and subsequent treatment it is often necessary to share information with appropriate schools, teachers, pediatricians, other treating professionals and agencies. In addition, insurance companies frequently request information in order for you to obtain reimbursement consistent with your policy. We will not use or disclose your child's information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time.

In addition, you always have the right to access the protected information and to amend, but not change, anything that you feel is either missing or in error.

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ACKNOWLEDGEMENT OF RECEIPT OF FULL POTENTIAL RESOURCE CENTER OFFICE POLICIES

I hereby acknowledge receipt of the Office Policies, including Privacy and Confidentiality, of Donna G. Orloff, M.A., CCC/SLP and the Full Potential Resource Center and agree to the obligations and responsibilities as described.

Responsible Party Signature: ____

Relationship to Child: ______________________ Date: _____________________

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CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION AS REQUIRED FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Name of Child: ____

I hereby authorize and direct Donna Glaser Orloff, MA, CCC-SLP, to perform all appropriate assessment and treatment procedures on the above named client. I further authorize and direct Donna Glaser Orloff, MA, CCC-SLP, to release to appropriate agencies, insurance companies, or others who are financially liable for said client's medical care, any and all information that is required to obtain payment for speech and language services. I further authorize and direct Donna Glaser Orloff, MA, CCC-SLP, to release to appropriate agencies/facilities/schools/related professionals any information acquired in the course of her evaluation and subsequent treatment.

Responsible Party Signature: ____

Relationship to Child: ______________________ Date: _____________________

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CONSENT FOR TREATMENT VIA TELETHERAPY

CONSENT FOR TREATMENT VIA TELETHERAPY:
The provision of speech and language therapy services via Teletherapy involves the use of audio, video or other electronic communication as a means to interact with your speech and language pathologist or reading/learning specialist for treatment.

RISKS AND LIMITATIONS of TELETHERAPY:
1. Technical failures
2. As the teletherapy session is not being recorded, and the session is private, just between your child and the therapist, no violation of privacy issues should occur.
3. Unauthorized access to transmitted information
4. Decreased availability of the therapist in the event of a crisis.

BENEFITS of TELETHERAPY:
1. Continuity of care and building on previously established progress while unable to attend in-person,-face-to-face therapeutic services.
2. Continued access to services.

CONFIDENTIALITY:
All existing confidentiality protections under federal and New York law apply to information used or disclosed during teletherapy sessions.

RIGHTS:
You may withdraw your consent for teletherapy services at any time before and/or during the teletherapy services without affecting your right to future care or treatment. By signing below, you are acknowledging that the specifics of the provision of speech and language teletherapy and or reading/learning services has been discussed with you, all of your questions about it have been answered, and you agree to receive teletherapy services.

____________________________________ _________________
Signature of Client Date

____
Printed Name of Client

____________________________________ _____________
Signature of Client's Parent/Legal Guardian (If Minor) Date