Simone Hüls, Ph.D., CCC-SLP
Licensed Speech-Language Pathologist (CA SP 25805)
Phone: 805-858-9222 x700 Fax: 805-460-6818
Email: speechwithsimone@gmail.com
Website: www.speechwithsimone.com
Office: 5975 Entrada Ave. Atascadero, CA 93422

OFFICE POLICIES AND FEES

Hello! Welcome to Speech with Simone. I am excited to work with you! Below you will find information about my office policies and fees. Please read it carefully and jot down any questions you may have so we can discuss them. When you sign this document, it will represent an agreement between us.

APPOINTMENT POLICY

Your appointment is reserved just for you. I will make every effort to be ready and available at our scheduled start time. In the event I am unable to attend our session (due to an emergency or illness), I will do my best to contact you as soon as possible. Intake sessions typically last 60 minutes, and follow-up sessions are generally between 30 and 45 minutes. It is important that we finish our appointment at the designated time, so I can write notes and be prepared for my next appointment. Please note, if we start our session late because you were running a few minutes behind, I will not be able to extend our session at the end. In addition, if you are significantly delayed, we may need to cancel the appointment altogether as a very short session may not be clinically productive. If this is the case, you will still be charged for the appointment unless a special circumstance exists.

CANCELLATION POLICY

Please call or email at least 24 hours before your appointment if you need to cancel or reschedule. I understand that special circumstances sometimes occur and that 24-hour notice is not always possible. If special circumstances such as illness or an emergency do not apply, and you miss your appointment or do not provide 24-hour notice, you will be charged for the full appointment fee. As a courtesy, I provide client with one “free pass” on late cancellations. Once you have used up this free pass, you will be charged for further missed appointments. Please be advised that insurance companies may not reimburse you for missed appointments.

HEALTH POLICY

Please strongly consider rescheduling if you are ill – this will help prevent the spread of illness to me and other clients (some of whom may have compromised immune systems). A child must be temperature-free for 24 hours before returning to therapy. If your child has experienced vomiting and/or diarrhea, he/she should not return to therapy until 24 hours have passed since the last episode of the same. Please do not bring sick or febrile family members to the clinic. Children will not be seen if any of the following is present: Too ill or uncomfortable to function in the therapy setting, continual runny nose; thick or discolored nasal discharge; excessive sneezing or coughing and mucus-producing cough; an elevated temperature.

INSURANCE AND FEES

While I participate on some insurance panels, there is no guarantee that your sessions will be covered. For example, you may have a deductible that has not been met. In addition, insurance companies have different criteria for determining whether speech-language services are “medically necessary." If we meet and you do not meet criteria for a speech-language diagnosis, your insurance will not cover the session. Ultimately it is your responsibility to contact your insurance company to determine your outpatient speech therapy benefits. Similarly, if your insurance company requires prior authorization

and you have not obtained it, the cost of that visit will be your responsibility. If your insurance changes during your treatment, it is your responsibility to provide that information to me, along with any authorizations required by your new plan. If your insurance requires a copay, it will be due at the time of service. Payment is due at the time services are rendered unless you have made other arrangements in advance. **Accounts more than 30 days overdue will be subject to a $20.00 late fee and 5% interest charge. Accounts more than 90 days overdue will be sent to collections**.

I participate with some insurance companies, but not all. If I am not contracted with your insurance, I will be happy to provide you with a superbill to assist you in seeking reimbursement for out-of-network provider services. Please also be advised that many health insurance plans have limited coverage for speech-language pathology services. I recommend that you contact your insurance company to discuss the limits of your coverage.

CONFIDENTIALLITY

Your privacy is very important to me. In particular, you should be aware that I will only contact you via means that you have specifically authorized in your new client paperwork. If you would like us to exchange information with persons other than yourself, an Authorization for Release of Information form must be completed.

NOTICE OF NONDISCRIMINATION

My office does not discriminate on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, age, or disability. I will provide free, timely, appropriate aids and services, including qualified interpreters for people will disabilities. I will provide language assistance, including translated document and free, timely, oral interpretation.

______ CONSENT/PAYMENT FORM

This form must be completed before services can be initiated. If the client is under the age of 18 years, the form must be signed by all legal guardians. By signing this form, you attest to the following: I have voluntarily applied for and entered into treatment, or give consent for the minor or person under my legal guardianship to be treated by Simone Hüls, PhD. I understand that I may terminate these services at any time.

______ RECEIPT OF POLICIES AND PROCEDURES

I hereby attest that I have received a copy of Simone Hüls's Policies and Procedures, including payment policies, and have read, understand and consent to be bound by its content.

______ RECEIPT OF PATIENT'S RIGHTS

I hereby attest that I have received a copy of the Patient Rights notice, have read, and understand its content.

______ RECEIPT OF PRIVACY POLICY AND CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

I have been provided a copy of Simone Hüls's Notice of Privacy Policies detailing how my medical record may be used and disclosed under Federal and State law. I understand that as a part of my treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice. I understand that I may revoke this consent in writing, except to the extent that the organization has

already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Simone Hüls may refuse to treat me. I further understand that Simone Hüls reserves the right to change privacy policies and will provide me with a copy of any revised notice.

By signing below, I acknowledge that I have read and understand the preceding information. My signature also **authorizes payment of insurance benefits** to Simone Hüls, Ph.D., 5975 Entrada Ave., Atascadero, CA 93422 for services rendered. I further authorize the release to my insurance company of any medical or other information necessary to process my insurance claims. I understand that I am responsible for all balances not paid by my insurance company, including, but not limited to, deductibles, coinsurance, and copays.

____ _________________________
Client/Parent Signature Date

FEES

The first session (assessment session) ranges from $108-$240, depending on the type of assessment and follow-up sessions are $95. Other services including report writing, telephone conversations lasting longer than 10 minutes, multiple/lengthy email exchanges, attendance at meetings you have authorized, preparation of records or treatment summaries, and the time spent providing other professional services you request will be charged at my hourly rate of $50. Activities will be charged in 15-minute segments.

____ _________________________
Client/Parent Signature Date

CONTACTING ME BETWEEN SESSIONS

I am often not immediately available by phone (due to not answering my phone while in session). Feel free to leave a message and I will return your call when I am able. Please note, I generally do not check my messages after 6:00pm or on the weekends. You may also email me, but I do not monitor my email at night or on weekends. Please be aware that if you do use email, you accept the risks associated with electronic communication.

If you live in San Luis Obispo County, it is possible we may occasionally see each other outside of your appointment(s). Because I want to maintain your confidentiality and privacy, I will not initiate any communication. If you feel comfortable, you may say hello and I will respond accordingly. Small talk is appropriate; however, we should not discuss clinical issues outside of your appointments. Similarly, to help protect your confidentiality and preserve therapeutic boundaries, I do not “follow” or “friend” my clients in online platforms or social media.

CLIENT PORTAL

You will have access to a client portal called TheraBook that you may use for scheduling appointments and updating your contact information. Although the technology is not currently in place, TheraBook plans to develop a client portal for client/therapist communication. The information on the portal meets high levels of security; however, no electronic communication is completely free of risk of hackers, etc. Nonetheless, this is much more secure than typical email messages and I would generally encourage you to use it instead of email.

ENDING OUR AGREEMENT

I will continue to consider you a therapy client unless you fail to attend two consecutive sessions and/or fail to return my attempts to communicate. If I leave two messages and send one written letter and do not hear from you, I will consider our therapy agreement null and void.

NOTICE OF PRIVACY POLICIES

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information. Our Legal Duties State and Federal laws require that I keep your medical records private. Such laws require that I provide you with this notice informing you of our privacy of information policies, your rights, and our duties. I am required to abide by these policies until replaced or revised. I have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. I respect the privacy of the information that you provide me and I abide by ethical and legal requirements of confidentiality and privacy of records.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is my policy not to release any information about a client without a signed release of information except in certain emergencies or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

ABUSE

If a client states or suggests that he or she is being abused by a child or adult, or has recently abused a child or vulnerable adult the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, I may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

COMPLAINTS

If you have any complaints or questions regarding these procedures, please contact me, Simone Hüls at (805) 858 9222, and I will get back to you in a timely manner. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. There will be no retaliation for filing a complaint with either me or the Office of Civil Rights.

PATIENT RIGHTS

As a recipient of services with me, I would like to inform you of your rights. Below is a description of each of your rights. If at any time you feel your rights have been violated, please contact me.

- You have the right to refuse or terminate services at any time for any reason. Your participation in services is voluntary.

- You have the right to submit complaints or suggestions at any time. I will fully investigate any complaints and seriously consider any suggestions you have for improving the services I provide.
- You have the right to information regarding the cost of services. I will always inform you of charges before I provide a service. A schedule of fees can also be obtained from me at any time.
- You have the right to privacy. Please see the Notice of Privacy Policy for information regarding certain limits to confidentiality and how your protected health information will be used.
- You have the right to know under what conditions I will terminate services. Please refer to the Policies and Procedures document for this information.
- You have the right to be informed of any changes in my policies. You will always be notified of policy changes that are relevant to the services provided.
- You have the right to request to review or receive your medical files. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $10 and $.25 per page, plus postage. There is a minimum charge of $25 for any forms completed by the provider.
- You have the right to cancel a release of information by providing me with a written notice.
- You have the right to restrict which information might be disclosed to others. However, if I do not agree with these restrictions (mandated reporting), I am not bound to abide by them.
- You have the right to request that information about you be communicated by other means or to another location.
- You have the right to disagree with the medical records in our files. You may request that this information be changed. Although I might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.
- You have the right to know what information in your record has been provided to whom. You have the right to request a copy of this notice.

AUTHORIZATION

Your signature below indicates that you have read and understood the information in this document and agree to abide by its terms during our professional relationship.

____ ______________________
Client Name (Printed) Date

____
Client Signature

____ ______________________
Simone Hüls, Ph.D., CCC-SLP Date