Bloom & Be Therapy and Educational Services, LLC
2809 W Godman Ave. Suite 3, Muncie, IN 47304
765-273-3279
intake@bloomandbetherapy.com

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Bloom & Be is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared:
https://www.bloomspeechandlanguage.com/wp-content/uploads/2021/09/hipaa-form.pdf

I acknowledge that I have seen a copy of Bloom & Be's HIPAA Notice of Privacy Practices (above) that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

I understand Bloom & Be cannot disclose my health information other than as specified in the notice.

I understand that Bloom & Be reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.
Please Note: It is your right to refuse to sign this Acknowledgement.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

Bloom & Be
Therapy and Educational Services

Acknowledgement & Assumption of Risk

I, _____ (client or parent/guardian name) understand that I am being asked to carefully read each of the provisions in this form. I acknowledge and agree to have _____ (client name) receive therapy services from Bloom & Be and/or any employee or independent contractor employed by Bloom & Be.

I acknowledge that there are some inherent risks associated with the use of therapy equipment that cannot be eliminated regardless of the care taken to avoid injuries.

I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding Bloom & Be and/or any employee or independent contractor employed by Bloom & Be accountable for any losses, injuries or other damages occurring to the client and/or myself. I further understand that I am fully responsible for my own safety.

Consent for Services

_____ I authorize Bloom & Be to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Bloom & Be in writing. In addition, Bloom & Be may terminate services by notifying me in writing.

_____ I do not give my consent or am withdrawing my consent regarding Bloom & Be rendering evaluation and therapy services to the client named below.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

Bloom & Be
Therapy and Educational Services

Pediatric Intake Form

Client Information:
Child's Name**:**
Name child goes by (if different)**:**
Street Address**:**
DOB**:**
City, Zip:

How did you hear about Bloom & Be?

Parent/Guardian Information
Who does the child primarily reside with (list primary contact first)?

Name**:**	Name**:**
Relationship**:**	Relationship**:**
Occupation**:**	Occupation**:**
Best method of contact?	Best method of contact?
Phone/Text**:**	Phone/Text**:**
Email**:**	Email**:**

Please list the names/ages of any siblings (please include “half” and “step” siblings.)

Emergency Contact Person: _____
Phone: _____
Relationship to child: _____

Physician Name: _____
Practice Name: _____

Insurance (please attach cards or present for copies)
Primary Insurance:_____
Policy Number: _____Group Number:_____
Policy Holder (if other than client):_____Date of Birth:_____
Secondary Insurance: _____
Policy Number: _____Group Number:_____
Policy Holder (if other than client): _____Date of Birth:_____

Client History
Is the child adopted? Yes No
If yes, at what age? _____

Is the child currently in foster care? Yes No

If yes, for how long has this child been with you? _____

How long has this child been in foster care? _____

Were there any complications during pregnancy? Yes No
If yes, please explain:

Was there any alcohol or drug use during pregnancy? Yes No
If yes, please explain:

Was the child born pre-term? Yes No
If yes, what was gestational age?

Was the child hospitalized after birth? Yes No
If yes, please explain:

Was the child part of a multiple birth (twins, triplets, etc.?)?Yes No

Please describe any other complications/injuries during pregnancy or birth not listed above:

Has the child ever been hospitalized? Yes No
If so, for what reason?

Is your child taking any medication? Yes No
If so, type and dose?

Please circle any existing diagnoses given by a medical professional (doctor, psychiatrist, psychologist, speech-language pathologist, audiologist, occupational therapist, physical therapist, etc.):

Autism	Emotional Disorder	Recurrent Ear Infections
Seizures	ADHD or ADD	Genetic Syndrome
Recurrent Fevers		Cleft Lip
Allergies	Hearing Impairment	Vision Problems
Cleft Palate	Dyslexia	Cognitive Impairment
Learning Disability		Other:

Additional Information about any of the above diagnoses:

Has your child had a hearing screening or evaluation? Yes No
Was it normal? Yes No
If not, please explain _____

Does your child currently have or has he/she had PE tubes? Yes No
Does your child have a history of chronic/recurrent ear infections? Yes No

If so, please give the approximate date of the last ear infection _____

Where does the child primarily spend his/her day? (Circle one)
School/Daycare (include name): Babysitter/Nanny
With a relative With one parent With both parents
Other _____
Are there other languages spoken at home or in primary care environment? Yes No
If so, which language(s)?
If so, in which language does the child prefer to communicate?

Does your child currently receive any type of special education? Yes No
If so, please explain:
Does your child currently receive any private services, either at home, in a clinic, or in the outpatient setting? Yes No
If so, please explain:

Milestones/Developmental Questionnaire:
About what age did your child (if applicable)…
Begin to make sounds _____ Begin to copy sounds _____
Say his/her first word _____ Begin putting 2 words together _____
Begin crawling _____ Begin walking _____
Begin eating solid foods _____ Begin using whole sentences _____
Begin reading _____

Did your child babble or make play noises during infancy? Y / N
Does your child make their needs and wants known? Y / N If yes, please describe how:
_____
Does your child have swallowing or feeding difficulties? Y / N If yes, please describe:
_____
Does your child name people and objects in their everyday environment? Y / N
Does your child attempt to imitate your speech? Y / N
How much of what your child says do unfamiliar people understand? All Some None
Does your child get frustrated when trying to communicate? Y / N
Can your child follow simple (one-step) directions? Y / N
Estimate of Spoken Vocabulary:
☐ 25 words or less ☐ 25-50 words ☐ 50-100 words ☐ More than 100 words
Does your child have difficulty producing specific sounds? Y/N Which sounds? _____

OBSERVATIONS AT PLAY
How long does your child sit and play?
What toys does your child like to play with?
_____
What are some of your child's favorite activities?

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Therapy and Educational Services

ADDITIONAL COMMENTS

Below please write any additional comments you feel would help us get to know your child (strengths, behaviors, interests, dislikes, etc.):

Please briefly explain why you are seeking an evaluation and your chief concerns in the home Environment:

Please briefly explain your chief communication or behavioral concerns in the school environment (if applicable.)

What is one goal you'd like to see your child accomplish in the next 6 months?

What about the next 5 years?

Bloom & Be
Therapy and Educational Services

Communication Preference Form

Client Name: _____ Date of Birth: _____

In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to me such as clinical documentation, appointment reminders, therapy updates etc. I hereby grant permission to Bloom & Be to do the following:

Written Documentation and Verbal Information

_____ I grant permission to provide me with written communication via HIPAA compliant encrypted email service via my email provided.

_____ I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

_____ I grant permission to provide me with written communication via USPS in an unmarked envelope.

_____ I elect to receive clinical information in person or via telephone through the number provided.

_____ I grant permission to leave relevant medical information on my answering machine or voicemail. I also give permission to release medical information pertaining to the client to the individuals listed below:

Sharing of Information

Individual's Name	Relationship to Client	Email Address and/or Phone Number
1.		
2.		

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

Bloom & Be
Therapy and Educational Services

Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs, are essential for therapeutic success.

While Bloom & Be understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or “no shows”. Please adhere to the following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted 24 hours prior to your scheduled appointment, barring extenuating circumstances.

A fee of $30 may be assessed to non-Medicaid clients if the following occurs. This fee will be billed directly to the client and not their health insurance company, as medical insurance does not provide coverage for missed sessions.
-If cancellations are made less than the required 24 hours
-If the client fails to show up for a scheduled appointment

If you cancel or are late for more than 25% of sessions in a quarter OR no-show 2 sessions in a row, the office will reserve the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be canceled if the client is more than 10 minutes late.

I, _____, understand the attendance / cancellation policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

Bloom & Be
Therapy and Educational Services

Authorization for Credit Card Use

By signing this form you give Bloom & Be permission to charge your account for the amount indicated on or after the indicated date. This is permission for current and future services as outlined in this agreement, and does not provide authorization for unrelated debits or credits to your account. **You can choose to provide your card info now, or fill the card number out when you receive your first invoice from Stripe.**

Name on Card: _____

Billing Address: _____

Credit Card Type:
☐ Visa ☐ Discover ☐ Mastercard ☐ American Express ☐ FSA
☐ Other _____

Credit Card Number: _____ Expiration Date: _____
Card Identification Number: _____ (3 digits on back of card)

> I authorize Bloom & Be to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for therapy services, for the amount invoiced by the practice, and is valid for ongoing monthly and weekly services. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

I understand that the provided credit card will be charged for services rendered by the end of the week of a session and that I will receive a confirmation of payment from Stripe.

Name: _____ Signature: _____ Date: _____

Client Name: _____ Date of Birth: _____

Bloom & Be
Therapy and Educational Services

Payment Policy & Fee Schedule

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and Bloom & Be for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member for any remaining amount insurance does not pay or for any services for which a client is uninsured. As a client of Bloom & Be you are required to carefully review and sign our payment policy. For clients who are paying privately, a Good Faith Estimate will be provided yearly.

Please read the following information carefully:

All therapy fees (including session fees and/or co-pays, if applicable) are due within 5 days of invoicing.

We accept the following payment methods at this time: check, credit card, ACH, transfers, and HSA cards.

Checks should be made payable to Bloom & Be Therapy and Educational Services.

Superbills can be provided upon request.

Bloom & Be will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial outside of our typical involvement with prior authorizations.

***

By my signature below, I hereby assign, transfer and convey to **Bloom & Be Therapy and Educational Services, LLC** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third-party payor with regard to these services, which authorization shall include authority to request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy. In addition, the provider has the authority to request and receive any coverage denial letters, Explanations of Benefits,

and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me.

I understand that if fees are not paid in full, treatment sessions may be postponed or canceled until payment is received.

I understand that all returned checks will be subject to a $35 returned check fee. Charges incurred and not paid after 90 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

I understand that I am responsible for all legal and collection fees, which Bloom & Be may incur if payment is not made in accordance with the terms and conditions herein.

I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 1 week after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used when able, all other refunds will be issued by a check. Client's who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____

Print Name of Client Date of Birth

_____ _____

Signature of Client, Guardian or Responsible Party Relationship to Client

Bloom & Be
Therapy and Educational Services

Consent and Release of Photographs / Videos

I give consent to Bloom & Be or any party authorized by Bloom & Be to photograph and/or video record in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to educational publication, for teaching purposes, and demonstration of progression of his/her skills.

I authorize Bloom & Be to use pictures of client for promotional purposes (ex. brochures, website, etc.)

I acknowledge that I will receive no financial compensation for providing consent since my participation with Bloom & Be in providing my consent and release is voluntary.

I hereby release Bloom & Be, their contractors, their employees and/or any third parties involved in the creation or publication of Bloom & Be. Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent and release.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client