

**Twomey Speech & Language Services**  
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Speech-Language Pathologist  
Diagnostic and Speech-Language Therapy Services

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## **Policies and Procedures**

(Updated January 1, 2015)

Welcome to Twomey Speech and Language Services, Karen W. Twomey, Licensed Speech-Language Pathologist. I am pleased that you have selected me to provide speech-language services for your child. I look forward to working with you, and helping your child achieve success developing his/her communication skills. The following policies and procedures help me to provide quality care for my clients and families. Please read the information below carefully and initial next to each section indicating you understand the information presented. If you have any questions or require clarification, please feel free to speak to me.

### **Evaluation / Therapy Services:**

\_\_\_\_\_ Speech-language evaluations are typically administered within 1-2 hours and they may be completed in a couple of sessions. Upon completion of scoring and data analysis a written evaluation report will be provided to parents / legal guardians. For home-based evaluations, a parent or designated adult or caregiver must be in the home during the session.

\_\_\_\_\_ Speech-language therapy sessions are scheduled in 1 hour blocks with 45-50 minutes of direct therapy with 10-15 minutes provided for consultation with parents or caregivers. For home-based therapy sessions, a parent or designated adult or caregiver must be in the home during the session.

\_\_\_\_\_ In order for therapy to be most successful, it is important for you and your family / caregiver to play an active role to facilitate your child's speech and language skill development. I may encourage you to work on a specific skill or skills between sessions. I may assign "homework" and completion of these tasks will encourage greater carryover of learned skills outside of therapy sessions.

\_\_\_\_\_ I recognize professional speech-language services are not only provided during my appointment time, but also during the 24 hours prior to and following my session.

### **Cancellations:**

\_\_\_\_\_ Your appointment time is set aside specifically for you. Should you need to cancel an appointment, please give as much notice as possible. If you need to cancel an appointment with less than 24 hours notice, you will be charged \$25, exceptions being if your child is ill or in the event of an emergency. I will need to charge you the full amount for the scheduled session for therapy "no shows", including if I arrive at your home or child's school / daycare, and your child is not present. These fees cannot be billed to your insurance company and they are the sole responsibility of the client / family. Should it be necessary for me to call you and cancel a therapy session on short notice, I will find a convenient time for you to make up the session.

### **Fee for Services:**

\_\_\_\_\_ A copy of the current fee schedule for diagnostic evaluations and speech-language therapy services will be given to you. I am a participating provider for Blue Cross / Blue Shield of Massachusetts, Tufts Health Plan, and Harvard Pilgrim Health Care. Although I am not affiliated with any other insurance carriers; upon request, I am able to provide you with the necessary documentation (receipt of payment, etc.) for you to submit to your insurance company for reimbursement. Insurance co-payments and out of pocket expenses for therapy services are due at the time services are rendered. Payment for a diagnostic evaluation is payable upon completion / receipt of the evaluation report. Insurance co-payments for diagnostic services are also due at the time of the evaluation session. Checks and cash are both accepted for services and I will provide you with a receipt of payment.

**Referrals:**

\_\_\_\_\_ If you are required to have an authorization in place prior to receiving care from a specialist, please contact your primary care physician prior to your appointment.

**Non-Covered Services:**

\_\_\_\_\_ Not all therapy services are considered to be medically necessary and they will not be paid by some insurance companies. I will do my best to inform you ahead of time for any therapy services that have been denied in the past for this reason. You will be responsible for payment should therapy services be denied for this reason.

**E-Mail, Cell Phones:**

\_\_\_\_\_ E-mailing and texting are very convenient ways to keep in touch: however, I am unable to guarantee your confidentiality with these types of communication. Please know that I will take care to insure confidentiality with these technologies should you wish to use them; however, all e-mails are kept in the logs of Internet service providers. Please make your e-mailing preferences known in the intake paperwork.

**Changes in Policy:**

\_\_\_\_\_ I have the right to make policy or procedure changes at any time. Clients will be informed of any policy or procedure changes prior to their implementation.

**Confidentiality and Records:**

\_\_\_\_\_ The information you share with me both verbally and written is part of your protected health information (PHI) and it is considered to be confidential. Detailed information regarding your protected health information and confidentiality limitations are located in the Notice of Privacy Practices.

**Ethical Considerations:**

\_\_\_\_\_ You can be assured that my services will be rendered in a professional manner consistent with the ethical standards of the American Speech-Language and Hearing Association (ASHA). If at any time you feel that I am not performing in an ethical or professional manner, please let me know right away so we may work to resolve your concern.

**Authorization:**

\_\_\_\_\_ I hereby authorize payment directly to Karen W. Twomey, Speech-Language Pathologist for services rendered. I understand that I am financially responsible for charges not covered by my insurance company and I agree to pay all the required deductible and co-insurance payments required by the policies of my insurance coverage. I understand that co-payments and out of pocket payments are due at the time speech-language services are rendered. Out of pocket payments for evaluations are due upon completion / receipt of the evaluation report.

\_\_\_\_\_ I hereby authorize Karen W. Twomey, SLP to release my protected health information acquired in the course of my treatment to the insurance company or any party involved in reimbursement of the claim.

Client Name (Printed): \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Legal Guardian (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_

