Little Bug Speech & Language Therapy

800 W Williams St, Ste 231-N • Apex, NC 27502 • P: (919) 610-9298 • F: (844) 587-9553 • info@littlebugspeech.com

Dear Parents,

In order to get started with speech therapy services including screening, evaluation, and treatment, we ask that you submit the following initial paperwork to **Little Bug Speech Therapy**:

1. A copy of the front and back of the policy holder's insurance card.

2. A copy of the front and back of the patient's insurance card.

3. Signed copies of the following forms:

    - Permission Form
    - Consent for Release of Information
    - HIPPA Authorization
    - Payment Policy & Agreement
    - Cancellation Policy
    - Case History Form

Please complete the Case History Form to the best of your ability. This will help us better understand the needs of your child.

You may fax or mail the completed and signed initial paper work to Little Bug Speech Therapy at:

Little Bug Speech Therapy
800 W. Williams St., Suite 231-N
Apex, NC 27502
Fax: (844) 587-9553
Email: meghan@littlebugspeech.com

We look forward to working with you to facilitate and improve your child's speech and language skills. Please do not hesitate to call us at (919) 610-9298 if you have any questions about the required forms or about our speech therapy services in general.

Updated July 2020

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IMPORTANT REMINDERS:

1. Little Bug Speech Therapy will submit claims to your insurance company. Little Bug Speech therapy is NOT responsible for claim denials. Parents and/or guardians are responsible for payment of any portion not covered, or denied, by insurance.

2. Little Bug Speech Therapy is also NOT responsible for discrepancies in claim processing from benefit information quotes. Quite often, insurance companies will tell us speech will be covered (over the phone),and will deny claims at claim processing. Little Bug is not responsible for these discrepancies.

3. Little Bug is not responsible for tracking visit limits associated with your insurance plan. This is your responsibility and you will owe any portion not covered by insurance due to visit limits being met.

4. Little Bug will send an invoice on a monthly basis for all services that were rendered in the previous month. For example, you will receive an invoice around the 1st or 2nd of each month of all services that took place in the previous month. Invoices will be sent via email OR paper mail, depending on family preference specified in the following paperwork. Failure to remit payment on invoice due date will result in Little Bug processing your credit card on file.

5. If paying for services with a benefit card, HSA or FSA card, you must call our office at 919-610-9298 to process payment. These cards cannot be processed online.

6. Services cannot begin without a credit card on file. This card will NOT be processed unless in the case of nonpayment or late payment.

7. When able, your therapist must be notified of cancelations at least 24 hours prior to the missed appointment. Failure to notify your therapist in a timely manner will result in a full-service charge of $60 for the missed session.

8. Little Bug reserves the right to suspend services after 3 no-shows within 1 month.

9. Please contact your therapist directly at her email address or cell phone for all matters related to therapy and your appointments. Our office hours vary each day of the week, so please keep your therapist cell phone number.

10. On occasion, Little Bug does welcome college students to observe therapy sessions. Please let your therapist know at the start of services if you would prefer your sessions not be observed.

11. We do require a copy of your insurance card at the start of therapy services.

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PAYMENT POLICY & AGREEMENT

Little Bug Speech Therapy is currently an in-network provider for Medicaid. If your current insurance provider is Medicaid, benefits will cover 100% of the payment for the evaluation and therapy. **Little Bug Speech Therapy** will bill Medicaid for evaluations and therapy. It is the parent/guardian responsibility to notify Little Bug Speech Therapy of discontinued coverage with Medicaid. Parents/guardians will be billed for all services not covered by Medicaid when Medicaid does not reimburse. If you have primary insurance in addition to Medicaid, you MUST provide the primary insurance information to Little Bug to ensure proper billing.

Little Bug Speech Therapy is also currently an in-network provider for Cigna, United Health Care (UHC), Aetna and BlueCross BlueShield (BCBS). **Little Bug Speech Therapy** will proceed with billing Cigna, UHC, Aetna and BCBS for services rendered. With this billing option, you may be responsible for a coinsurance/co-pay which will be billed to you on a monthly basis. You will be responsible for any deductibles that apply. Should your insurance carrier deny or fail to pay your claim, or fail to pay your claim in full and in a timely manner, you as the parent/guardian will be responsible for payment of the services and/or the payment balance which was not covered by insurance.

We also accept private/out-of-pocket payment. It is the responsibility of the parent or guardian to file all non-Medicaid, non-Cigna, non-UHC, and non-BCBC insurance claims if you so choose. **Little Bug Speech Therapy** will provide all clients with a detailed invoice for services rendered that can be submitted for insurance claims by the parent and/or guardian. **Little Bug Speech Therapy** will provide additional information on services rendered upon request should your insurance carrier request more information beyond the invoice. Please note that it is the responsibility of the parent and/or guardian to contact their insurance carrier to determine the required documentation for filing insurance claims.

Patients will be billed on a monthly basis for services rendered. Payment is due within 14 days of invoice date. Failure to make any payment will result in your child's services being put on hold until payments are received, and your account is paid in full. If you pay by check and that check bounces, you will be charged a $25.00 fee. **A $25 Late fee will be added to unpaid invoices every 14 days until payment is made. Little Bug Speech Therapy reserves the right to charge your credit card on file for any payment not made within 14 days of the invoice date.**

Parents and/or guardians must also notify **Little Bug Speech Therapy** if your child's physician or insurance coverage change. You will be responsible for payment of services if you did not notify Little Bug of updated insurance information, especially in cases where prior-authorization was required prior to insurance being billed. Most insurance companies will not back date insurance authorizations.

Little Bug Speech Therapy is not responsible for tracking benefit information. This includes any visit limits, out of pockets or deductibles that are listed on your plan. You will be responsible for any portion of services not covered by insurance due to a visit limit being met.

***Little Bug Speech Therapy will ONLY submit claims to your insurance company. Little Bug Speech is not responsible for denials or nonpayment by insurance. Little Bug Speech Therapy is also not responsible for obtaining or tracking benefit information. It is parent/guardian responsibility to research benefit information and track any visit limits or deductibles which apply.**

As the parent or guardian, I have read the above information and understand **Little Bug Speech Therapy's** Insurance Policies and Authorization to Release Information. I accept all terms and conditions.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

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CANCELLATION & NO-SHOW POLICY

Missed Sessions/Cancellation Policy

We request that you notify us 24 hours prior to your appointment if you need to cancel or reschedule. Failure to call or be present for an appointment is considered a missed appointment. **Little Bug Speech Therapy** will charge the patient or the responsible parent/guardian the rate of a normal visit for all missed appointments. Please note that insurance providers do NOT reimburse for missed appointment charges. If your child misses 3 or more therapy sessions within a 6 week period, **Little Bug Speech Therapy** reserves the right to place your child's services on hold until scheduling conflicts are resolved. A consistent schedule is pertinent to your child's progress in speech-language therapy. Please help us serve you better by keeping scheduled appointments or calling at least three hours prior to reschedule.

Illness Policy

If your child has a fever, a persistent cough, or a runny nose, please call and cancel your appointment. Because of the close proximity of the therapist to the child's face, it is easy for the virus to be spread. Your therapist needs to see many children over the course of the week and cannot afford to be out sick frequently. A general rule of thumb is that if a child has been on an antibiotic for 24 hours and does not have a fever, is not coughing frequently, and does not have a runny nose, he/she is probably not contagious. We appreciate your understanding and will be happy to reschedule your appointment. We have a 24-hour answering service, so feel free to call us at any hour and leave a message. We appreciate three hours notice if you are canceling; however, we also understand how illness in young children can occur suddenly, so you will not be penalized with a fee if you call and cancel for sudden illness.

Inclement Weather Policy

For clients that are seen in-home, **Little Bug Speech Therapy** reserves the right to cancel or reschedule appointments in the event of inclement weather. Our goal is to keep our therapists safe on the roads. For clients that are seen in day cares, we follow the same inclement weather policy as Wake County Schools. If Wake County Schools closes for the day, we will cancel all day care appointments for that day. If the county closes schools at noon, we will automatically cancel all day care appointments after 12:00. Many clients keep the same appointment time each week, in which case it is understood that you will be seen at the same time on the following week.

I have read and accept all policies pertaining to missed appointments, illness, and inclement weather.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

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PERMISSION TO SCREEN, EVALUATE AND/OR PROVIDE THERAPY

Patient Name_____ DOB_____

Parent Name_____

Primary Insurance Carrier_____Policy #_____

Please complete the form below to grant permission and authorize a screening, comprehensive speech and language evaluation, and/or treatment (as needed) for your child. Speech-language evaluations consist of standardized testing, informal and formal observations, and clinical judgment.

I, _____, authorize **Little Bug Speech Therapy**, to screen, evaluate and/or
(parent/guardian)

provide the necessary speech and/or language treatment/therapy/services to

_____. Treatment is based upon the findings of the evaluation and
(client)

the recommendations of the responsible speech-language pathologist.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Printed Name

You will be contacted regarding the results of the screening. A complete evaluation and/or subsequent treatment will only be administered after your therapist has spoken with you about the results of the screening and fees/insurance benefits. You will be asked whether you would like your child to receive a comprehensive evaluation and if an evaluation is agreed upon, a state-licensed and certified speech-language pathologist will administer the evaluation (including standardized evaluation tests, language samples, caregiver interviews, etc.). Your therapist will provide subsequent treatment, if needed, to the aforementioned child. Results of the evaluation will determine a treatment/therapy course that will include the recommendations of the speech-language therapist and input from the parent.

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CONSENT FOR RELEASE OF INFORMATION

Child's Name:_____ Date of Birth: _____

I, _____ (Parent/Guardian) hereby grant Little Bug Speech Therapy to communicate with the following person or agency:

Name of Physician	**Phone**	**Fax**
Address		

Insurance Company/Medicaid	**Phone**	**Fax**
Address		

OTHER: (If you would like us to communicate with any other professional/person regarding your child's communication skills, i.e., physical therapist, occupational therapist, etc, please list in the box below)

Name	**Phone**	**Fax**
Address		**Purpose**

_____ **Children's Developmental Service Agency (CDSA)**

Little Bug Speech Therapy may discuss and release to the aforementioned person or agency information including but not limited to: evaluation reports, treatment plans, progress notes and therapy documentation, previous medical history, as well as necessary verbal communication pertaining to the child. This information will be used for diagnostic and treatment planning purposes only. It is my understanding that this information will not be shared with any other entity without my prior knowledge. I further acknowledge that the use of this information is to ensure the best quality of care possible for my child.

_____ _____

Parent/Guardian Name Date

_____

Parent/Guardian Signature

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PATIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA AUTHORIZATION)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

YOUR PRIVACY RIGHTS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Little Bug Speech Therapy** is dedicated to ensuring the privacy of your child's speech and/or language evaluation findings and course of therapy treatment. In serving our patients, we create records regarding treatment and services that are provided in order to have accurate information and ensure the appropriateness and efficiency of treatment services. Federal law requires us to strictly protect any personally identifying information on your child. This notice discloses our policies regarding the storage, use, and sharing of confidential patient information. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

Little Bug Speech Therapy, PLLC is required by law to keep your health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history
- Your test results
- Treatment notes
- Insurance information

A government rule requires that you get a copy of this privacy notice. This rule is called the Health Insurance Portability and Accountability Act, or HIPPA for short. We will ask you to sign a paper acknowledging that you have been given this notice.

How Your Health Information May Be Used or Shared

We may use your health information without your permission for the following reasons:

1. **Treatment:** We may share your information with doctors or other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.

2. **Payment:** We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for therapy services. This may include sharing important medical information. We ma share information to:
    a. Get the insurance company's permission to start treatment
    b. Get permission for more treatment
    c. Get paid for the treatment you receive

3. **Health Care Operations:** We may use and share your health information to run the clinic and make sure all patients receive good care. For example, we may use your health information to:
    a. See how well our services are working
    b. See how well our staff is doing
    c. See how we compare to other clinics and private practices
    d. Make our services better
    e. Help others study health care services

Your health information may also be used or shared without your permission for:

- **Abuse and Neglect:** We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
- **Appointment Reminders:** We will use your information to remind you of upcoming appointments. Reminders may be sent in the mail, by email, or by phone call or voicemail message. If you do not wish to get reminders, please tell your speech-language pathologist.
- **As Required by Law:** We will share your information when we are told to by federal, state or local law. We will also share information if we are asked by the police or courts.
- **Government Functions:** Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
- **Information About a Person Who Has Died:** We may share information with the coroner, medical examiner, or a funeral director, as needed.
- **Health-Related Benefits and Services:** We may use your information to let you know of other services that might be of interest to you.
- **Public Health Risks**: We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
- **Regulatory Oversight:** We may use or share your information to report to agencies overseeing health care. This may include sharing information for audits, licensure and inspections.
- **Threats to Health and Safety:** Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others.
- **Worker's Compensation:** We will share your information with Worker's Compensation if your case is being considered as a work-related injury.

When Your Permission is Needed to Use or Share Your Health Information

You must give us your permission to use or share your health information for any situation that is not listed on this notice. You will be asked to sign a form, called an authorization, to allow us to share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

Your Privacy Rights

You have the right to:

- **Ask us not to share your information:** You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
- **Ask us to contact you privately:** You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call you but not email. Or you may want us to call you at work and not at home. You must ask in writing.
- **Look at and copy your health information:** You have the right to see your health information and get a copy of that information at any time. You have the right to see treatment, medical and billing information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.

- **Ask for changes to your health information:** You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.
- **Get a report of how and when your information was used or shared:** You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this:
    - You need to ask us in writing.
    - You must tell us the dates you are asking about and if you want a paper or electronic copy.
    - You may get information going back six (6) years, but it cannot be for earlier than April 14, 2003. Tis is the date when the government privacy rules took effect.
- **Get a paper copy of this privacy notice:** You can get a paper copy of this notice at any time.
- **File complaints:** You can file a complaint with us or with the government if you think that
    - Your information was used or shared in a way that is not allowed
    - You were not allowed to look at or copy your information
    - Any of your rights were denied

Who is Covered by This Notice

The people that must follow the rules of this notice are:

- All speech-language pathologists at Little Bug Speech Therapy, PLLC.
- Anyone who is allowed to add health information to your file, including students and other staff
- Any volunteers who may help you while you are at this clinic/private practice

Changes to the Information in This Notice

WE may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

Complaints

You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts

If you have any other questions about this notice or your privacy rights, please ask your speech-language pathologist.

I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES DISCLOSED IN THIS NOTICE.

_____ _____

Parent/Guardian's Signature Date

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Acknowledgement That You Received Your Privacy Notice

Little Bug Speech Therapy, PLLC is required by law to keep your health information safe. This information may include:

- Notes from your doctor
- Your medical history
- Your test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of your privacy notice. Please retain a copy of this privacy notice for your records. This notice tells you how your health information may be used or shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have been given a copy of our privacy notice.

Client Name: _____

Client D.O.B: _____

Parent Name: _____

Parent Signature: _____

Date: _____

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CASE HISTORY FORM

Date (completing this form) _____

IDENTIFYING AND FAMILY INFORMATION

Person completing this Form _____ Relationship to Child _____

Child's Name _____ Gender _____ DOB (of child) _____

Address _____ City/Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Preferred method of contact:

☐ Cell ☐ Home Phone ☐ Work Phone ☐ Email

By signing below, I give permission for my child's therapist to communicate with me via email regarding test results, progress notes, and any other information pertaining to speech evaluations and sessions.

Caregiver signature _____ Date _____

PRIMARY INSURANCE:

Name, address, phone number of Insurance Company:_____ ___

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's Date of Birth: _____ Policy Holder's ID Number: _____

Patient ID Number (if different from Policy Holder's ID):_____ Group Number:_____

BILLING PREFERENCE: _____ PAPER MAIL _____ E-MAIL

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Mother's Name	History of Speech Delay	Occupation
_____	_____	_____

Father's Name	History of Speech Delay	Occupation
_____	_____	_____

Siblings	Age	Speech Disorder/Delays (if applicable)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? _____

Does the child speak the language?_____

Who speaks the language? _____

What is the child's primary language?_____

Current Pediatrician's name_____ Phone:_____

Physician's address:_____

Has your child had frequent ear infections? If so, how frequent? _____

Otological care? Surgery? _____

Date of Last Hearing Screening: _____

Do you have concerns about your child's hearing?_____

Does your child have any medical or school determined diagnoses? If so, please explain (include date of diagnosis)

_____

_____

_____

Does your child take any medication? If so, please list the medication and explain if and/or how these medications affect his/her behaviors as a result.

_____

_____

BIRTH HISTORY/DEVELOPMENTAL HISTORY

Mother's health during pregnancy:_____

Birth Weight: _____

Was child born premature? ☐ Yes ☐ No

Any complications during pregnancy or delivery

_____

Developmental Milestones

Achieved within normal limits? ☐ Yes ☐ No

If No to above, Please explain

_____

SPEECH DEVELOPMENT

Age of first word spoken _____

Concerns about your child's speech:_____

Do you have a family history of speech delays? If so, please explain.

_____

_____

_____

Please list previous speech-language evaluations. Please include the date of the evaluation, who conducted it, and what the results were. Please provide a copy, if able.

_____

_____

SCHOOL/ACTIVITIES

Name of school_____

Address of School_____

Does your child receive any special services (including speech therapy, occupational therapy, physical therapy, etc)?_____

****IF YOUR CHILD HAS A WAKE COUNTY IEP, PLEASE INCLUDE A COPY FOR YOUR THERAPIST!****

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I give permission for my child's therapist/Little Bug Speech Therapy to…
Communicate with me regarding therapy sessions (including progress, attendance, scheduling, etc.) via text, email and voicemail.

YES **NO**

Communicate with me regarding therapy sessions (including progress, attendance, scheduling, etc.) via written note home at daycare/preschool. I understand that these notes will be left in my child's backpack, cubby, folder, or wherever directed by my child's teacher or caregiver.

YES **NO**

Communicate with teachers and caregivers at my child's school/daycare regarding therapy evaluation results/sessions in order to help carry-over skills learned in speech sessions.

YES **NO**

Communicate with me via email regarding therapy. Some emails may include PDF attachments and Word documents which may or may not be password protected.

YES **NO**

I understand that…

If I want my child's therapist to communicate with anyone other than the parent/guardian of the child indicated on initial paperwork, I will sign and authorize consent to do so. I will request LBST to do so in writing.
Parent/Guardian Initials____

If a divorce or separation situation exists, a custody agreement and separation agreement will need to be shared with Little Bug Speech Therapy and my child's therapist. I will share custody agreements with my therapist/Little Bug Speech Therapy so that my therapist only shares information with legal guardians of my child.
Parent/Guardian Initials____

My child's invoice for speech services will be emailed or mailed to me. Information containing diagnosis codes, procedures codes, dates of service, cost of service and insurance plan information will be included on these invoices.
Parent/Guardian Initials____

If my child is being seen in a daycare/preschool setting, my child will be seen where the teachers/daycare/preschool director instructs therapy to occur. This could mean that therapy may occur in a public place, such as a hallway or resource room.
Parent/Guardian Initials____

My child's pediatrician will be sent orders for signature, as well as plans of care and progress notes.
Parent/Guardian Initials____

Parent/Guardian Signature **Date**

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Credit Card Charge Authorization Form

The undersigned hereby authorizes Little Bug Speech Therapy, PLLC to charge the below-referenced credit card for services rendered and any related expenses. In addition, I understand my credit card will be charged in the event that:

- I do not pay my invoice in full on the date it is due.
- Proper cancellation procedures are not followed as noted in the Cancellation and No Show Policy.
- A check is returned for insufficient funds (fee of $25.00)
- At discharge, if an account balance remains, your credit card will be charged for unpaid services to discharge date.

I, the undersigned, further understand it is my responsibility to inform Little Bug Speech Therapy, PLLC of any changes to my credit card information including address, zip code, updated expiration dates, account numbers and security codes.

PLEASE PRINT CLEARLY; CIRCLE ONE CREDIT CARD BELOW

VISA MASTER CARD DISCOVER AMERICAN EXPRESS

Account No. _____-_____-_____-_____Expiration Date: _____

Security Code:_____

Name as it appears on Credit Card: _____

Billing Address:_____

BY SIGNING BELOW, I UNDERSTAND THAT IF MY BALANCE IS NOT PAID IN FULL 5 DAYS AFTER MY PAYMENT IS DUE, THE ABOVE CARD WILL BE CHARGED FOR ALL PAYMENTS OWED TO LITTLE BUG SPEECH THERAPY.

Signature_____ Date_____

____YES, I WOULD LIKE THIS CARD SET UP FOR AUTOPAY EACH MONTH.

____NO, I DO NOT WANT THIS CARD TO BE USED FOR AUTOPAY EACH MONTH.

*****Therapy services will not begin until this form is returned to Little Bug Speech.*****

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Statement of Nondiscrimination

Little Bug Speech Therapy, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

I will visit www.littlebugspeech.com for more information regarding Little Bug Speech Therapy's policy in regards to nondiscrimination and language assistance services.

Parent/Guardian Signature_____ Date_____

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Teletherapy Consent Form

During the current COVID-19 public health crisis, Little Bug Speech Therapy, PLLC will offer teletherapy as an option to continue speech therapy services. This will be provided for the time period that the Center for Disease Control and the North Carolina Department of Health and Human Services continues to recommend social distancing. The health and safety of your child, your family, and our staff is our top priority.

Telepractice was approved by the American Speech-Language-Hearing Association (ASHA) as an appropriate method of service delivery in 2005. Telepractice is defined as the application of telecommunications technology to the delivery of speech language therapy and audiology professional services at a distance by linking clinician to client for assessment, intervention, and/or consultation. This means we are able to provide speech therapy services via online platforms in order to continue speech therapy during this time. Your child's speech therapist will join a computer-based session at the designated therapy time and would work on the same goals as in the office, home, daycare or school where services are typically provider.

This model of service delivery is supported by the American Speech Language Hearing Association and is payable by many insurance carriers per the Telehealth Enhancement Act of 2017—H.R.3306, 115th Congress. This mode of speech therapy delivery, when implemented correctly, is noted to have equal outcomes to face-to-face interventions.

By electronically signing and initialing below, I, _____consent for myself and my child, _____ to engage in teletherapy with Little Bug Speech Therapy, PLLC. I understand that teletherapy includes treatment using interactive audio, video, or data communications.

I understand the following as it relates to the use of teletherapy:

1. I have the right to withhold from teletherapy consent at anytime without affecting my right to future case or treatment.
   _____ (electronically initial)

2. There may be risks associated with the use of teletherapy despite reasonable efforts on the part of LBST, that: the transmission of my information could be disrupted or distorted by technical failures, internet outages, network connection difficulties, etc. LBST currently uses a HIPAA compliant platform (Zoom) to provide teletherapy services.
   _____ (electronically initial)

3. I am responsible for:
   -providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions.
   -for the information security on my computer
   -for arranging a location with sufficient lighting and privacy that is free from distractions or instructions for my teletherapy session
   _____ (electronically initial)

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4. I understand it is my responsibility to contact my insurance company or otherwise understand coverage for teletherapy under my policy as it relates to my child's speech therapy. I am responsible for any payment not covered by my insurance.
   _____ (electronically initial)

I have read, understand and consent to the information provided above.

Name of Parent/Guardian Date

Name of Child/Patient

Little Bug Speech & Language Therapy

800 W Williams St, Ste 231-N • Apex, NC 27502 • P: (919) 610-9298 • F: (844) 587-9553 • info@littlebugspeech.com

Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact and/or by contact with contaminated surfaces and objects, and even possibly in the air. People reportedly can be infected and show no symptoms and therefore spread the disease. The exact methods of spread and contraction are unknown, and there is no known treatment, cure, or vaccine for COVID-19. Evidence has shown that COVID-19 can cause serious and potentially life threatening illness and even death.

Little Bug Speech Therapy, PLLC cannot prevent you [or your child(ren)] from becoming exposed to, contracting, or spreading COVID-19 while utilizing Little Bug Speech Therapy, PLLC's services or premises. It is not possible to prevent against the presence of the disease. Therefore, if you choose to utilize Little Bug Speech Therapy, PLLC's services and/or enter onto Little Bug Speech Therapy, PLLC's premises you may be exposing yourself to and/or increasing your risk of contracting or spreading COVID-19.

ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 for myself and/or my children in order to utilize Little Bug Speech Therapy, PLLC's services and enter Little Bug Speech Therapy, PLLC's premises. These services are of such value to me [and/or to my children,] that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 in order to utilize Little Bug Speech Therapy, PLLC's services and premises in person rather than arranging for an alternative method of enjoying the same services virtually (e.g. videoconference).

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to bring suit against Little Bug Speech Therapy and its owners, officers, directors, managers, officials, trustees, agents, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to utilizing Little Bug Speech Therapy's services and premises. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

CHOICE OF LAW: I understand and agree that the law of the State of North Carolina will apply to this contract.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE:

Signature: _____ Date: _____

Name (printed): _____

I am the parent or legal guardian of the minor named above. I have the legal right to consent to and, by signing below, I hereby do consent to the terms and conditions of this Release.

Signature: _____ Date: _____

Name (printed): _____