Marvel Myo & Speech

PATIENT INFORMATION AND CONSENT

PATIENT INFORMATION

Patient Name:	Gender: ☐ M ☐ F	Date of Birth:
Mailing Address:		
City:	State:	Zip Code:
Parent/Guardian Name (if applicable):		Relationship:
Primary Email:	Secondary Email:	
Home Phone Number:	Cell Phone:	
Primary Care Physician:	Physician Phone:	
Physician Address:		
Any other specialists?		
Who referred you to MarvelMyo &Speech?		
Do you have any Speech and Language concerns?		
What do you hope to learn from MarvelMyo & Speech?		
What are your favorite activities/hobbies?		
Where do you attend school or work?		

PATIENT HISTORY

Patient Name:	Age:	Date of Exam:

As a baby were you breastfed or bottle-fed? ☐ Breastfed ☐ Bottle-fed ☐ Unknown	As a child, did you have a history of ear infections? ☐ Yes ☐ No ☐ Unknown
Did you have a complicated birth, C-section birth, or premature birth? Trouble latching or feeding?	
Comments:	
Have you ever had a finger or thumb sucking habit? ☐ Yes ☐ No	If yes, how long?
As an infant, child and/or adult, did you have any allergies? ☐ Yes ☐ No	

What are you allergic to?

How do you manage/treat symptoms?

Do you have a history of other breathing issues:

- ☐ Asthma
- ☐ Turbinate Reduction
- ☐ Airway Surgeries
- ☐ Chronic Nasal Congestion
- ☐ Sinus Infections
- ☐ COPD
- ☐ Deviated Septum
- ☐ Nasal Polyps
- ☐ Tuberculosis

Comments:

As an infant, child and/or adult, have you had issues with digestion, bloating or gassiness, or acid reflux?

Comments:

SPEECH

Have you ever been in speech therapy? ☐ Yes ☐ No	How long / what sounds?
Do others notice any problems with clarity, mumbling, voice projection, lack of facial movement?	

EATING, DRINKING, SWALLOWING

Do you have a hyperactive gag reflex? ☐ Yes ☐ No	Is it difficult for you to swallow pills? ☐ Yes ☐ No
Do you chew with your mouth open? ☐ Yes ☐ No	Do you feel like you need water to help wash down food as you eat? ☐ Yes ☐ No
Other/Comments:	

DENTAL /ORTHODONTIC

Do you have a history of tooth decay, gum disease, recession, or gum grafts?

Comments:

Have you had orthodontic treatment in the past? ☐ Yes ☐ No	If not, have you been evaluated? ☐ Yes ☐ No
Did you have premolars extracted? ☐ Yes ☐ No	Have you noticed that your teeth have shifted or changed (orthodontic relapse)? ☐ Yes ☐ No

Did you have:

☐ Expander ☐ Tongue crib/rake ☐ Head gear ☐ Elastics

Comments:

HEAD, NECK, TMJ

Have you ever used an occlusal guard/night guard? ☐ Yes ☐ No	
Headache Frequency - Scale of Pain from 0 to 10 (0 = No pain/10 The Worst Pain):	
TMJ or Facial Pain: ☐ Daily ☐ Weekly ☐ Monthly ☐ Sometimes ☐ Never	Scale of Pain from 0 to 10 (0 = No pain/10 The Worst Pain):
How do you manage or treat your pain? (Pain description, location):	
Comments:	
Posture Characteristics: ☐ WNL ☐ Rolled shoulders ☐ Forward head	What do you think of your posture?

FACIAL DEVELOPMENT

Facial Development: ☐ Low tone appearance ☐ Long/narrow face ☐ Dimpled chin ☐ Vertical angle or small mandible ☐ Gummy smile
Comments:

SLEEP

Do you snore? ☐ Yes ☐ No ☐ Unknown	Average hours of sleep each night?	Do you wake up feeling refreshed?
Are you tired during the day or do you feel chronically run down or fatigued? ☐ Yes ☐ No		
Have you been tested for sleep apnea? ☐ Yes ☐ No		
If yes, when and what was your diagnosis? AHI, RDI, oxygen desaturation:		
Do you have a CPAP or dental sleep appliance? ☐ CPAP ☐ Dental Appliance	Do you wear it? ☐ Yes ☐ No	
Comments:		

Marvel Myo & Speech

CONSENT TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION / WAIVER HIPAA LIABILITY

This seeks authorization for the use and/or disclosure of the specific personally identifiable health information set forth made pursuant to the requirements of 45 CFR§164.508, which states the federal privacy regulations of the Health Insurance Privacy and Accountability Act of 1996 and authorizes MarvelMyo & Speech to obtain the personally identifiable health information specifically referenced in this authorization.

- I give my consent to Katelyn Spencer with MarvelMyo & Speech to use and disclose PHI for treatment of the patient in accordance of the Notice of Privacy Practices.

- I Consent to the use and disclosure of the patient's protected health information to the referring physician/dentist/orthodontist (Check box ☐ and _____ initial if you do not want your physician/dentist/orthodontist to obtain the information) and any of the healthcare professionals and / or educators listed below. This will be done in accordance of the Notice of Privacy Practices.

- I have received a copy of the Notice of Privacy. ☐ Yes ☐ No Initials: _____

Name of Additional Professionals	Specialty (ENT, Dentist, Ortho, MD, etc.)	Phone

WAIVER OF HIPAA LIABILITY **Initials:_____**

- Due to federal guidelines protecting all private patient health information, MarvelMyo & Speech has a policy in place that prohibits discussion of all information regarding the patient's assessment, treatment, and care in public areas such as the patient waiting room. All discussion regarding the patient should take place in a private room away from the general public.

- By signing this waiver of HIPAA liability, you as the patient or guardian, is 1) agreeing not to initiate a conversation regarding patient health information in a public setting 2) releasing MarvelMyo & Speech from any harm or fault caused by discussions of the private health information in open access areas in our facility such as the waiting room with you as the patient or guardian.

- This waiver will be in place from the date signed below, until such a time that you as the patient or guardian request in writing to MarvelMyo & Speech that all discussion take place in a private setting.

AGREEMENT AND UNDERSTANDING OF OROMYOFUNCTIONAL THERAPY WITH MARVELMYO & SPEECH

- MarvelMyo & Speech reserves the right to terminate service. Referrals will be recommended if the therapist observes there is any kind of issue that impedes the airway/nasal breathing such as: tonsils, tongue tether, adenoid/turbinate's, and allergies. If the parent, caregiver, or patient will not have the issue taken care of, MarvelMyo & Speech has the right to terminate service. These things will not allow progression of therapy. Lastly, if there is noncompliance with exercises which will not allow for progress, MarvelMyo & Speech has the right to terminate service.

- It must be noted that successful completion of the oromyofunctional therapy program isdependent upon patient desire, good attitude and self-discipline. Parental involvement and encouragement are important and necessary. Only the dedicated participant and cooperation of the patient can guarantee effective swallowing and resting posture results. I give you my promise I will show up and give 100%.

Initial: _____

- DAILY practice of the exercises is important! Please make time in your schedule to focus on your "homework." Some exercises will be mastered in the first week. Others are designed to take a few weeks.

- Practice exercises a minimum of 2-3 times a day, 7 days a week. Most are incorporated in daily routine.

- Consistency is important! We understand that life is busy. We ask that you make every effort to show up weekly. Zoom or Theranest (teletherapy) will be utilized for each session. Typical oromyofunctional therapy programs are 12-15 sessions. Once a month the therapist will schedule an in-person session to check-in with you and your therapy because MarvelMyo & Speech firmly believes in the best patient care and having check-ins in-person allows for this. The in-person session is required for continuance of the program with MarvelMyo & Speech.

- ALWAYS use your mirror when doing exercises.

- We prefer to schedule a "set time" for each patient weekly or bi-weekly. Think of it as a scheduled music lesson or sports practice. Sometimes, other activities must be put on hold for a season so you can focus on your oral health! A few months of therapy can lead to a lifetime of positive change! YOU GET OUT OF IT WHAT YOU PUT INTO IT!

- Choose a quiet place where you can focus on your daily exercises. Try to avoid distractions.

- We understand that childcare can be difficult to arrange. It is preferred to only have the patient for therapy sessions. We ask that if you MUST bring another family member to an appointment, that they are quiet and do not cause distraction.

- In preparation for your first therapy session as part of the total cost of the oromyofunctional evaluation ($250), the myo tool kit is provided. MarvelMyo & Speech will provide the kit following your evaluation in-person or to your home address once payment has been received for the evaluation. Please do not begin using the therapy tools until you have met with your therapist and received instruction. Because supplies are very expensive only one replacement will be given if lost. After the first package the replacement will be $4.00.

- Sometimes the Myobrace Trainer or the Myo Munchee is use and other devices this will be an additional cost to parent or patient because it is an addition cost to therapist. Therapist will work with the patient prior to charging. MarvelMyo & Speech works very hard to keep cost down but, sometimes it is necessary to include props.

- The number of sessions needed varies greatly, depending on the client's individual case as well as their participation and cooperation in the therapy program. However, 15 sessions is the included number for an initial oromyofunctional therapy program with MarvelMyo & Speech. If you complete your myofunctional program prior to the 15 sessions (your therapist has provided written confirmation of your completion of the program), you will be refunded the difference of unused sessions. Again, most patients receiving oromyofunctional therapy tend to need 12-15 sessions.

MARVELMYO & SPEECH
PERMISSION FOR USE OF INFORMATION

PERMISSION FOR EXCHANGE OF INFORMATION

I give permission to exchange medical information, either written, electronically, or by phone, between my providers of medical and therapeutic services (or those of my child), as well as insurance providers. I understand that the purpose of this exchange is to allow for coordinated services between these providers.

Name of Patient (Printed): _____ Date: _____

Patient or Caregiver (Signature): _____ Date: _____

PERMISSION TO USE FILES FOR RESEARCH, PRESENTATION, PUBLICATION FOR MARVELMYO & SPEECH

I give my permission for use of photographs, videos and records made in the process of examination and treatment, to be used for the purposes of (check all that apply):

- ☐ Research
- ☐ Education, continuing education courses, presentation for educational purposes
- ☐ Publication on MarvelMyo & Speech of Texas
- ☐ Professional journals

Signed: _____ Date: _____

SPEECH THERAPY DISCLAIMER

In this practice, Oromyofunctional Therapy is not a speech therapy service and does not make claims to correct speech when a patient chooses to participate in this therapy. MarvelMyo & Speech does offer separate speech therapy evaluations and services available. Orofacial myology applies techniques which bring muscles of the face, tongue, and lips into balance so, that they may produce improved articulation. However, unless the muscles are in proper function a speech program cannot be achieved. The optimal treatment plan is based on the differential diagnosis by the referral source and the personal wants and needs of the client.

Signature: _____ Date: _____

Marvel Myo
& Speech

VIDEO/PHOTOGRAPH AUTHORIZATION

With today's advancements in technology we have the ability and benefit of capturing your time in therapy via photographs and video. The photos and videos will only be shared with those media platforms and caregivers/family members that you allow us to share permission with. If you allow for public viewing, please indicate this in the form. Otherwise, any video and photographs will be strictly confidential and not shared with the public.

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I **DO** give permission for my therapist to photograph or videotape me during my therapy sessions. I give permission for MarvelMyo & Speech to share my images and video on their social media platforms and to use them for marketing purposes and educational services only.

☐ I **DO NOT** give permission for my therapist to photograph or videotape me during my therapy sessions.

Release to photograph, film, or record vocally for publicity purposes, scientific and/or educational purposes I hereby grant to MarvelMyo & Speech, PLLC the right and authority to photograph, film, and/or record vocally:

Client Name: _____

Date of Birth: _____

☐ These records may be used for promotional or publicity purposes and may be published in mass media publications, on the MarvelMyo & Speech internet sites (website, Facebook, Pinterest or other) brochure, or for educational presentations. The patient's name and family's name will remain confidential. This release is effective until revoked in writing by the undersigned. Such revocation shall only be effective to prevent any expanded future use of the records.

☐ These records may be used for purposes of study, research, and teaching and may be published in scientific publications, or on the internet. The patient's name and family's name will remain confidential. This release if effective until revoked in writing by the undersigned. Such revocation shall only be effective to prevent any expanded future use of the records.

Note: I authorize this release based on the following conditions: These records become the property of MarvelMyo & Speech, PLLC or its representatives. This release is given without the promise of compensation. This release is effective until terminated by a retraction in writing from the person granting this authorization. The parent/legal guardian and the patient do release MarvelMyo & Speech, PLLC any right, title, and/or interest of any kind they may have in the records produced.

Parent/Guardian/Patient Signature: _____ Date: _____

Marvel Myo & Speech

FINANCIAL AGREEMENT/CONTRACT

COMMITMENT AGREEMENT

The success of the process of correcting the orofacial myofunctional disorder is dependent on attendance at agreed upon therapy sessions, daily exercises two or three times a day (and encouragement/supervision in the case of a child or patient mature level or cognitive ability). The total length of the treatment depends on severity of problem and cooperation of patient.

CANCELLATION POLICY

This policy requires at least 48-hour notice should you need to cancel an appointment. If you give less than 48-hour notice or fail to appear for your appointment, you will be charged a $115 full therapy appointment for cancellation/no show fee. If you are sick or there is a true emergency these would be the only valid excuses. This does include a full session of Teletherapy on Zoom or Theranest. When there is inclement weather, the therapist will do therapy via Teletherapy, so no need to cancel.

New Patient Evaluation/Therapy Supplies $250. ***Upcharge of 10% if credit card used.***

ACTIVE THERAPY SESSIONS

$115.00 per lesson plus upcharge of 10% if credit card used. Whichever visits not used and that are not planned to be used during that month and talked about between therapist and parent or patient will not count as a session so it will still be available. Teletherapy via Zoom or Theranest with a treatment plan will be charged just like a normal in person session. Following each session, the therapist will provide exercises to be done each week and patient will either text or email video back demoing the exercise and therapist will critique if needed with another video. This follow-up of treatment with video may occur weekly or bi-weekly depending on patient's plan of care. A treatment plan will be sent either through email, in chat during teletherapy, or through Theranest.

INSURANCE

This practice does not accept or file for insurance assignment for oromyofunctional therapy. If you are wanting both speech and oromyofunctional therapy services/evaluations then we can provide a Superbill following your month's sessions with billing codes for speech services but not for oromyofunctional therapy. There is no guarantee that your insurance company will reimburse for the services that MarvelMyo & Speech provides.

PAYMENT METHODS

Cash, Check, Credit Card. Upcharge of 10% in addition to therapy when credit card used.

Initial: _____

_____ Agrees to pay MarvelMyo & Speech in the manner and on the dates agreed upon.

Signature: _____ Date: _____

(For Agreement above)

Marvel Myo & Speech

HEALTH & SAFETY FOR HOME VISITS (IF SCHEDULED)

For the safety of our clients and therapists, we will be implementing the following procedures:

- Home visits may be scheduled if all members of a household are in good health.
- Temperatures of the patient and therapist will be taken before the session begins.
- Therapy should be conducted in an area that has less house traffic and has been properly sanitized.
- Other family members will not be allowed to participate in therapy sessions.
- Therapist will wear a mask +/- face shield and gloves.
- Only materials that can be easily sanitized will be allowed during therapy sessions.
- Therapist will continue to practice proper hand sanitizing before, during and after every session.

Marvel Myo & Speech

CONSENT TO TREATMENT AND COMMUNICATION PREFERENCE

CONSENT TO TREATMENT

Initials:_____

I voluntarily consent to any and all recommended diagnostic procedures and treatment provided by MarvelMyo & Spech.

- I am fully aware that orofacial myofunctional therapy, speech, language, and feeding therapy are not an exact science and I am aware that no guarantee has been or can be made as to the results of the treatments at MarvelMyo & Speech.
- I will pay in full at time services are rendered.
- We may from time to time take photographs of patients during their course of care with us.
- We only use these photos for local purposes.
- Do you consent to having you/your child's photograph taken? ☐ Yes ☐ No

COMMUNICATION PREFERENCE

Initials:_____

Protecting the privacy of your child and your family is extremely important to us, and HIPAA mandates it. While we prefer to give you updates in person after therapy, there will be times when you will want us to send you written information. The HIPAA privacy rule allows us to communicate with you electronically provided that we apply reasonable safeguards when doing so, including encryption, limiting personally identifiable information like full names, etc. The privacy rule does not prohibit the use of unencrypted email and text for treatment related communications, if the patient or the parent of the patient prefers and requests it. Please understand that if you prefer to receive unencrypted emails and texts, then there is a risk that a third party may be able to obtain that information during transmission or while stored on a computer or phone.

For written progress reports, appointment reminders, updates, etc., you have my permission to: (Check all that apply)

☐ Send unencrypted emails and I fully understand the risks. (If you do not select this option, we will only send encrypted emails from our HIPAA compliant mail service.)

☐ Send unencrypted text messages to my mobile phone and I fully understand the risks. (If you do not select this option, we will not send or reply to any text messages.)

☐ I prefer encrypted emails.

☐ I prefer that you send written information via USPS or other mail only.

Marvel Myo & Speech

ON FILE CREDIT CARD INFORMATION

☐ Mastercard ☐ Visa

Card Number: _____

Expiration Date: _____ Security code on back of card: _____

Card Member Signature: _____

This signature verifies that this card may be charged for payment of services when no other payment has been received.

Any unpaid account shall be increased three percent each month beginning 30 days following the date payment was due. Any remaining amount due, including any unpaid charges previously made, shall be increased at the same rate on the first day of each succeeding month until paid. If it becomes necessary to seek legal assistance for the outstanding balance of this account. In addition, no new appointments will be made unless previous appointments are paid for.

Marvel Myo & Speech

FINANCIAL RESPONSIBILITY AND PAYMENT TERMS

FINANCIAL RESPONSIBILITY AND PAYMENT TERMS

Initials:_____

We are in the business of caring for our patients. That is our passion, but it is a business. So, we hope that you will help us by following these payment terms for either receiving speech therapy and/or oromyofunctional therapy.

(Patient or Guardian) _____ Agrees to pay MarvelMyo & Speech in full for the evaluation following the service provided. Patient agrees to pay MarvelMyo & Speech in full for therapy sessions (either 15 for oromyofunctional therapy) or on a monthly (1st of the month) basis for speech-language therapy, as deemed by the evaluation and therapists' decision for plan of care. The number of Speech and Language sessions (including feeding therapy) are determined following the full evaluation (typically 2-3 sessions per week at 30-45 minutes).

- Evaluation Rate - Oral Motor or Speech $ 250.00 (includes therapy kit)
- Evaluation Rate - Oral Motor and Articulation/Language $300.00
- Therapy Session Rate for Oromyofunctional Therapy - $115.00 /1/2 hour (15 session plan of care)
- Therapy Session Rate for Speech Therapy and Oromyofunctional Therapy - $145/45 minutes
- Therapy Session Rate for Speech Therapy ONLY - $65/1/2 hour; $75 for 45 minutes