C.A.S.T

Children's Advanced Speech Therapy/ Therapy Consortium

SPEECH • FEEDING • AAC

Welcome to C.A.ST!

Welcome to Children's Advanced Speech Therapy! We are honored to support your child and family. This packet outlines important policies, consent forms, expectations, and procedures designed to help create a collaborative, safe, and effective therapeutic environment.

Contact Information

Therapist Name: Corisa Aufmuth

Fax: (854) 600-1643

Website: caspeechtherapy.com

Email: corisa@caspeechtherapy.com

Therapy Session Expectations & Service Delivery

- Therapy sessions are scheduled for 60 minutes unless otherwise specified by the treating Speech-Language Pathologist due to insurance limitations, authorization requirements, or CPT coding guidelines.
- Therapist arrival and departure times may vary by approximately 15 minutes due to scheduling logistics, traffic, travel between visits, or unexpected delays.
- Therapy time will be flexed to ensure that your child receives the full therapeutic service time whenever possible.
- Typically, approximately 50–55 minutes of the session will involve direct client interaction. The remaining portion of the session may include caregiver education, home exercise program (HEP) development/review, progress review, clinical documentation, goal updates, care coordination, and therapeutic planning.
- Documentation is considered part of the therapeutic service process and directly supports treatment planning, progress monitoring, caregiver education, and continuity of care.
- The therapist may complete documentation in the home setting when appropriate or in the vehicle prior to traveling to the next client. Documentation time may vary depending on treatment complexity, payer requirements, and billing codes.

HIPAA Notice & Privacy Practices

- Children's Advanced Speech Therapy, LLC is committed to protecting the privacy and confidentiality of your child's protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA).
- Your child's medical and therapy information will only be shared for purposes related to treatment, payment, healthcare operations, or when otherwise permitted or required by law.
- Records may be shared with physicians, schools, occupational therapists, physical therapists, insurance companies, or other providers involved in your child's care when appropriate and authorized.
- You have the right to request copies of records, request corrections, request restrictions on disclosures, and receive a list of certain disclosures.
- Electronic communication such as email or text messaging may carry some privacy risks.
- Reasonable safeguards will be used whenever possible.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

Consent for Evaluation & Treatment

- I authorize Children's Advanced Speech Therapy, LLC and its treating clinicians to provide speech-language, feeding, AAC, and related therapeutic services to my child. I understand that treatment plans may be adjusted based on clinical judgment, progress, and ongoing assessment.
- I understand that participation and carryover at home are important for progress.
- I understand that therapy outcomes cannot be guaranteed.
- I consent to communication with healthcare providers, schools, or other related professionals involved in my child's care as necessary for coordination of services.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

Photo, Video & Social Media Consent

Children's Advanced Speech Therapy may occasionally request permission to use photographs, videos, or recordings for educational, marketing, training, or social media purposes.

_____ **YES**, I consent to the use of my child's image/video for educational or marketing purposes.

_____ **NO**, I do not consent to the use of my child's image/video.

I understand that names and identifying information will not be shared without additional written consent.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

Therapist Rights, Professional Boundaries & Grounds for Discharge

To maintain a safe, ethical, and effective therapeutic environment, Children's Advanced Speech Therapy reserves the right to discontinue or discharge services under certain circumstances.

- Repeated no-shows, same day/late cancellations, or attendance inconsistencies that significantly interfere with therapeutic progress.
- Repeated exposure of the therapist, staff, or other families to contagious illness due to noncompliance with illness policies.
- Aggressive, threatening, inappropriate, hostile, discriminatory, or unsafe behavior directed toward the therapist or staff by patients, caregivers, or others present during sessions.
- Failure to comply with recommended safety procedures during sessions.
- Failure to maintain communication necessary for scheduling, care coordination, or treatment participation.
- Nonpayment for private-pay services or outstanding balances when applicable.
- Situations in which the therapist determines that services are no longer clinically appropriate, beneficial, or within the scope of practice.

Whenever appropriate, reasonable notice and recommendations for alternative resources or referrals may be provided prior to discharge. However, Children's Advanced Speech Therapy reserves the right to immediately discontinue services in cases involving safety concerns, harassment, threats, or severe policy violations.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

Corisa Aufmuth, M.S.Ed. CCC-SLP
Speech Language Pathologist
Children's Advanced Speech Therapy, LLC

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Attendance and Cancellation Policy

Why Attendance Matters: Regular attendance is important for making meaningful progress in speech and language therapy. Missed sessions can interrupt your child's momentum and limit their progress.

Scheduling:

- Appointments are scheduled in advance and are reserved specifically for your child.
- We strive to maintain consistent weekly times when possible.

Cancellations:

- Please provide at least 24-hour notice if you need to cancel or reschedule a session. This includes notifying therapist of school or daycare closures that will impact a scheduled session.
- aExceptions to 24-hour notice are for illness related cancellations only. Documentation from a doctor may be requested for frequent illness related cancellations.
- You may call, email, or text to cancel.

Late Cancellations & No-Shows

- Private pay clients may be charged a $50 fee for late cancellations (less than 24-hour notice) or no-shows. This fee is not billable to insurance.
- Exceptions may be made for illness or emergencies at the discretion of the therapist.

Frequent Cancellations/ Attendance Policy

- Three (3) no-shows or cancellations within a 30-day period may result in your child being removed from the schedule or placed on a waitlist. The Therapist will provide a "final notice" before this occurs,
- Consistent attendance is important to maintain your reserved appointment slot.

Late Arrivals

- If you arrive late, the session will still end at the scheduled time.
- If you arrive more than 15 minutes late, the session may be considered a no-show.

Illness Policy -Please cancel your child's session as soon as possible if they are experiencing:

- Fever (within the last 48 hours) — child must be fever-free without the use of medication for 48 hours.
- Vomiting or diarrhea (within the last 48 hours)
- Contagious illness (e.g., flu, COVID, strep throat, etc.)
- Severe cough or respiratory symptoms
- If your child is taking medication for a cold or illness, please inform the therapist to help prevent the spread of potential illness across the caseload.
- Please note, the therapist may also need to cancel sessions due to illness or illness within their family. In such cases, the therapist will make every effort to offer a make-up session as scheduling allows.
- Therapist reserves the right to cancel or end a session early if your child is showing signs of illness

Professionalism and Respect Toward Therapists

All clients and family members/guardians are expected to treat our therapists with courtesy, respect, and professionalism at all times- whether in person, over the phone, or through written communication. Disrespectful, aggressive, or inappropriate behavior towards staff will not be tolerated. If such behavior occurs, we reserve the right to discontinue services for your child without a warning

Acknowledgment

By signing below, I confirm that I have read and understand the attendance and cancellation policy. I understand that fees may be charged for late cancellations or no-shows (for private pay clients), and that

consistent attendance is necessary for my child to receive effective services.

Parent/Guardian Signature: _____

Parent Guardian Printed Name:_____

Date_____

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Illness Policy

Dear Families,
Please review our illness policy. These guidelines help keep all of our children, families, and staff healthy and safe:

Please cancel your child's session if:

- Your child has a fever (must be fever-free for 48 hours without medication before returning).
- Your child has tummy troubles (must be vomit- or diarrhea-free for 48 hours before returning).
- Your child is sick with congestion, cough, or respiratory illness (viral or otherwise).
- Your child has been exposed to COVID-19 or influenza — please notify therapist as soon as possible.
- Your child has any contagious illness (such as strep throat, RSV, croup, etc.).
- If your child is taking medication for a cold or illness, please inform the therapist to help prevent the spread of potential illness across the caseload.
- Please note, the therapist reserves the right to cancel a session after arrival if a child is showing signs of illness.

This policy is made to protect every child and family on caseload; including the infants and medically fragile children on caseload and within staffs personal life. Your cooperation helps keep everyone safe and allows therapists to continue providing consistent care to all families.

Continuous noncompliance with this policy will be grounds for dismissal following a warning conversation and a review of documentation.

Cancelled sessions due to illness are ALWAYS appreciated, a makeup session will offered when your child is symptom free and feeling better!

Thank you so much for your support and understanding — it truly makes a difference.

Acknowledgment

By signing below, I confirm that I have read and understand the illness cancellation policy. I understand that continued disregard for this policy is grounds for dismissal following a conversation with my provider and review of documentation.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

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