Speech Within Reach

Consent for Services

I authorize Speech Within Reach Therapy Services, PLLC 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 Speech Within Reach Therapy Services, PLLC in writing. In addition, Speech Within Reach Therapy Services, PLLC may terminate services by notifying me in writing.

_____ _____

Print Name of Client Date

_____ _____

Signature of Parent or Legal Guardian Relationship to Client

HIPAA Privacy Notice

Speech Within Reach 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
- Medical history
- Testing 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. 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.

_____	_____
Print Name of Client	Date
_____	_____
Signature of Parent or Legal Guardian	Relationship to Client

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 Speech Within Reach Therapy Services for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of Speech Within Reach Therapy Services you are required to carefully review and sign our payment policy.

Please read the following information carefully:

All therapy fees (including session fees and/or co-pays, if applicable) are due at the time of service

We accept the following payment methods: cash, check, or credit card.

We will provide you with an invoice outlining the services rendered and the amount charged.

I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are “not covered” or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that Speech Within Reach Therapy Services, PLLC will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

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

I understand that all returned checks will be subject to a $15 returned check fee. Charges incurred and not paid after 30 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 Speech Within Reach Therapy Services, PLLC 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 2 weeks 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; all other refunds will be issued by a check. Clients who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

I understand the payment policy and the risks of not adhering to it.

_____	_____
Print Name of Client	Date
_____	_____
Signature of Parent or Legal Guardian	Relationship to Client

Authorization to Exchange, Obtain, Or Release Information

Client Name: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip: _____
I _____ (parent/guardian) hereby grant Speech Within Reach Therapy Services, PLLC permission to communicate with the following person or agency:
Name: _____
Contact Information: _____

Information to Be Released:

- Medical History
- Therapy Evaluation
- Treatment Notes
- School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of:

- Coordinating care with other professionals
- Providing continuity of services
- Updating therapeutic progress

I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax. I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.

_____ _____
Print Name of Client Date

_____ _____
Signature of Parent or Legal Guardian Relationship to Client