SPEAKFREELY

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Patient Name

CONSENTS AND PRIVACY ACKNOWLEDGEMENT

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Initials

Consent for Care and Treatment: As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's therapist as necessary in her judgment. I understand that my child is under the care and supervision of my therapist.

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Initials

Consent for Student Observation: I understand that Speak Freely supports the education of students of Speech-Language Pathology and that students may observe or participate with clients in therapy, under supervision.

□ *I consent to have students in the same treatment area with my child.*

□ *I do not consent to have students in the same treatment area with my child.*

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Initials

Acknowledgement of Notice of Privacy Practices: I acknowledge Speak Freely will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. A copy of the Notice of Privacy Practices was provided to me, if requested, with further detailed information about how protected medical information is used and/or disclosed about my child for treatment, payment, healthcare operations, and as otherwise allowed by law.

INSURANCE INFORMATION

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Initials

Insurance Coverage Disclaimer: It is the clients' responsibility to know what their insurance will or will not cover. It is also the clients' responsibility to inform Speak Freely of any changes to their insurance plan, or associated benefits, in a timely manner. Speak Freely asks, in order to perform diagnostics and therapy, that you sign this disclaimer accepting responsibility for payment for any and all expenses that are not covered benefits of your insurance.

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Initials

Insurance Billing: Speak Freely will file all insurance claims for Health Insurance plans that it is an in-network provider. All other insurance claims are the clients' responsibility to file accordingly. Speak Freely will provide all the necessary forms and information in order for clients to file with their insurance provider.

PHOTOGRAPHY AND VIDEO RELEASE FORM

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Initials

I hereby authorize Speak Freely to photograph or video my child for the purposes of treatment, education, and professional reasons. I understand that my child may be in group pictures or videos that may also be reviewed by others outside of Speak Freely. I also understand that if pictures of my child are used for advertisement or marketing purposes, Speak Freely will request consent from me prior to use. This authorization is valid for the duration of my child's therapy from the date signed below. I understand that I may revoke this authorization at any time, but will not hold the therapist and/or staff of Speak Freely responsible for pictures or videos already taken of my child.

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Signature of Child's Legal Guardian

_____
Printed Name

_____
Date