CONSENT FOR CARE & THERAPY

I, the undersigned, do hereby agree and give my consent for Therapy for Language and Communications, LLC, to furnish care and treatment to _____ that is considered necessary and proper in diagnosing or treating his/her speech, language and communication condition.

_____ Responsible Party Initials/date

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize ***Therapy for Language and Communications, LLC*** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to ***Therapy for Language and Communications, LLC*** from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between ***Therapy for Language and Communications, LLC*** and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize Therapy for Language and Communications, LLC, to release all information necessary, including medical records, to secure payment.

_____ Responsible Party Initials/date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the ***Therapy for Language and Communications, LLC*** Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to ***Therapy for Language and Communications, LLC*** to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and ***Therapy for Language and Communications, LLC*** will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicated below are individuals whom ***Therapy for Language and Communications, LLC*** may speak to regarding my treatment. Please list names.

☐ spouse _____ ☐ father _____

☐ mother _____ ☐ other _____

Listed below are individual(s) whom I request restriction regarding my protected health information.

☐ Not Applicable

☐ _____

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers you provide us?

☐ Yes: Home Mobile Work Other: _____

☐ No

_____ Responsible Party Initials/date

SIGNATURE for CONSENT

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the ***Consent for Care and Therapy***, the ***Authorization*** to release all information necessary to secure payment and the ***Consent For Use and Disclosure of Health Information.***

Patient / Guardian/Responsible Party Signature: _____ **Date** _____