



Speech and Language Services

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CONSENT FORM

I voluntarily consent to care at Communication Works, LLC, which may include routine assessment and/or treatment by a licensed, certified speech-language pathologist. I am aware that speech-language pathology is not an exact science, and I acknowledge that no guarantees or assurances have been made to me as the result of services, procedures, treatments or evaluations at Communication Works, LLC.

Use and Disclosure of Protected Health Information

- I understand Communication Works maintains paper and/or electronic records that may describe my history as it relates to communication, as well as assessment results, diagnoses, recommendations, treatment plans, and/or progress.
- I understand it may be necessary for Communication Works to disclose my protected health information to another entity as part of regular assessment, treatment, or payment operations, and I consent to such disclosure for these purposes.
- I authorize Communication Works to release any information regarding services rendered by them to my health insurance company.
- I will allow a photocopy of my signature to be used to file insurance.
- I understand my protected health information may be shared verbally, via paper, or in an electronic format.
- I have been provided with a *Provider Notice*, which more fully describes how my health information may be used or disclosed.

Payment Policy

- I understand Communication Works will file claims with all private insurance companies for speech-language treatment, assessment, and other related services.
- I understand Communication Works does not accept Medicare or Medicaid at this time.
- I authorize my insurer to issue payment for approved services, rendered by Communication Works, directly to Communication Works.
- I understand if my insurance policy covers speech-language services, I must pay Communication Works any coinsurance/copayment/deductible on each day of service.
- I understand if my insurance policy does not cover speech and language treatment, assessment, or related procedures, I am personally responsible for the cost of service, as identified on the Self-Pay Reduced Fee Schedule, which will be provided to me.
- I understand if I am a self-pay client, payment must be made in full on each day of service.
- I understand, if requested, Communication Works will send me an electronic receipt each time I make a credit card payment.
- I understand, if requested, Communication Works will send me a statement, via email which will be locked after five days.
- I agree if, for any reason, my account should become delinquent I will pay for all collection and legal fees.

Health Insurance Information

Name of Insurance Company _____

Name of Policy Owner _____ DOB _____ Relationship to Client _____

Employer Group _____ Group # _____ Member ID # _____

Number of Insurance-Approved Therapy Sessions _____ Effective from this date _____ Until this date _____

Cancellation and No Show Policy

- I will make every effort to be present and on time for every scheduled session at Communication Works.
- I will notify Communication Works and/or my clinician at least 12 hours in advance if I must miss an appointment.
- I understand that I may be charged for missed appointments not cancelled at least 12 hours in advance.
- I understand that inconsistent attendance and/or more than three 'No Shows' may be cause for terminating services.

I certify that I have read and fully understand this Consent Form.

Client Signature

Relationship to Client

Date of Signature

Persons 18 years of age or younger must have a parent or guardian sign the form on their behalf.