communication works
Speech and Language Services
1550 South 70th Street, Suite 200
Lincoln, NE 68506

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SERVICE CONSENT FORM

Client_____

I voluntarily consent to services at Communication Works, LLC, which may include routine assessment and/or treatment by a licensed, certified speech-language pathologist and/or occupational therapist. I am aware that speech-language pathology and occupational therapy are not exact sciences, 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, assessment results, diagnoses, recommendations, treatment plans, and/or progress relating to communication and/or occupational therapy.
- 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 and/or occupational therapy 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 and/or occupational therapy 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, language or occupational therapy treatment, assessment, or related services, 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.
- I agree if, for any reason, my account should become delinquent I will pay for all collection and legal fees.

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 canceled at least 12 hours in advance.
- I understand that inconsistent attendance and/or more than three 'No Shows' may be cause for terminating services.

Health Insurance Information

Name of Insurance Company_____

Name of Policy Owner_____ DOB_____ Member ID #_____

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

Printed Name_____ Relationship to Client_____

Signature_____ Date_____

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

communication...the essential human connection
~ Ashley Montagu