



Speech and Language Services

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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, occupational therapist (OT), and/or physical therapist (PT). I am aware that speech-language pathology, OT, and PT 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, occupational therapy, and/or physical therapy, including treatment, assessment, and other related services.
- I understand Communication Works does not accept Medicare or Medicaid, and that I am personally responsible for the cost of service.
- 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, OT, and/or PT services, I must pay Communication Works any co-payment on each day of service.
- I understand if I owe a deductible or coinsurance, Communication Works will send me a statement each month, payable upon receipt.
- I understand if my insurance policy does not cover speech-language, OT, and/or PT, I am personally responsible for the cost of service, and that information about the cost of service will be provided to me by the billing/insurance department.
- 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 that if I do not pay my bill on time, services may be suspended until the bill is paid in full.
- 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 a \$40 'No Show' fee if I fail to cancel a scheduled appointment.
- I understand that inconsistent attendance and/or more than three 'No Shows' may be cause for terminating service.

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.

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.