communication works
Speech • Language • OT • PT
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SERVICE CONSENT

Client_____

I voluntarily consent to services at Communication Works, which may include routine assessment and/or treatment by a licensed, certified speech-language pathologist, occupational therapist (OT), and/or physical therapist (PT). I know speech-language pathology, OT, and PT are not exact sciences. I acknowledge that no guarantees or assurances have been made regarding services, evaluations, treatment, or procedures at Communication Works.

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, OT, and/or PT.
- I understand Communication Works may need to disclose my protected health information to another entity as part of regular assessment, treatment, or payment operations. I consent to such disclosure for these purposes.
- I authorize Communication Works to release any information regarding their services 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 electronically.
- 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 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 I am personally responsible for the cost of services.
- 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 that if my insurance policy does not cover speech-language, occupational, and/or physical therapy services, I am personally responsible for the costs. The billing/insurance department will provide me with information about self-pay fees.
- I understand if I am a self-pay client, payment must be made in full on each day of service.
- I understand that Communication Works will send me an electronic receipt each time I make a credit card payment if I request it.
- 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 that if my account becomes delinquent for any reason, I will pay all collection and legal fees.

Cancellation and No-Show Policies

- I will make every effort to be present and on time for every scheduled session at Communication Works.
- I will notify my clinician at least 12 hours in advance if I must miss an appointment.
- I understand that I may be charged $50 for a late cancellation or a No-Show.
- I understand that inconsistent attendance and/or more than three 'No-Shows' in a six-month period may be grounds for terminating service.

Health Insurance Information

Name of Insurance Company_____ Member ID#_____

Name of Policy Owner_____ Date of Birth_____

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.