RALEIGH PRIMARY
PEDIATRIC SPEECH THERAPY

2604 Falls River Ave • Raleigh, North Carolina 27614 • Tel 252-342-4189

Consent and Authorization for Services and Treatment for: _____

(patient's name)

- This patient or legal guardian gives consent for procedures and treatment as ordered by physician or developmental evaluation center. I understand and agree that Raleigh Primary Pediatric Speech Therapy, will not be liable in the event that scheduled services cannot be provided as requested, or when insufficient notice is given concerning canceled services.

- With this consent, Raleigh Primary Pediatric Speech Therapy, may call, email or text clients in reference to any items that assist in the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to clinical care. It is our philosophy that communication is a vital part of effective therapy. My preferred form of communication is:
  o Email: _____Text: _____ Phone call: _____
  o I do not wish to receive these reminders: _____ (initial here)

- **Patient Acknowledgement of Notice of Privacy Practices**
  I acknowledge by signing below that I was made aware of the HIPPA Privacy Practice.

- **Authorization to Release**
  This patient or legal guardian consents to the release of information by a school, hospital, physician, developmental evaluation center, health department, or other agency where child was evaluated to Raleigh Primary Pediatric Speech Therapy. I also authorize Raleigh Primary Pediatric Speech Therapy to disclose all or part of my medical information to any agency to benefit my care such as coordinators, daycare staff, teachers, family members, members of IEP, IFSP team, physicians, nutritionists, orthotist, and _____. This release is valid for seven years from date signed below. You may revoke your authorization in writing at any time.

- **Client Financial Responsibility**
  With this consent, I understand that if payment is not made to Raleigh Primary Pediatric Speech Therapy by other payers or by client's family, I will be responsible for the services rendered to my child. This payment will be made dependent upon a written notice. I understand that I am responsible for insurance deductibles and amounts not covered by any insurance or payment provider. In the event that you carry an account balance 60 days from your initial statement, you will be assessed a late fee of 15% of the balance (minimum of $20) monthly until paid in full. If the balance is not paid upon the 120th day, your account will be sent to a third party collection agency. Raleigh Primary Pediatric Speech Therapy will provide all clients with an itemized invoice for services that can be submitted to insurance claims by the parent and/or guardian. Additional information can be provided as requested from insurance carriers. If you have insurance coverage questions, please contact your insurance provider. Clients will be provided a weekly, bi-weekly or monthly invoice as agreed upon. Payment is due in full within 15 days of invoice date in the form of cash, a personal check, or a credit card.

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- **Attendance, Cancellation, and Illness Policy**
  Repeated cancellations may result in either forfeiture of permanent appointment or termination of service. Failure to contact Holly L. Ellis prior to appointment time will be a no show and a full fee-for-service may be charged. Due to the nature of home health therapy, a 15 minute window should be allowed for the therapist to arrive. We will contact you if we are going to be later than 15 minutes for an appointment. If a parent or guardian cancels 50% of the sessions for two consecutive months or has 3 no show no calls, Raleigh Primary Pediatric Speech Therapy reserves the right to discontinue services with the family. We ask if a session is missed by either the therapist or the client, there is an attempt made to reschedule. As we see many children in the community we do our very best to provide a clean environment. We ask if your child has had any fever, vomiting, or diarrhea within the last 24 hours that you let us know so we can reschedule the appointment.

Client's Name **DOB**

Printed Name (Parent/Legal Guardian)

Signature (Parent/Legal Guardian) **Relationship to Client Date**