1911 W C St
Jenks OK 74037

INFORMED CONSENT FOR SPEECH, PHYSICAL, AND/OR OCCUPATIONAL THERAPY, PSYCHOLOGY, AND BEHAVIORAL HEALTH

In coming to the Speech Language Pathologist, Physical Therapist, and/or Physical Therapist Assistant, and/or Occupational Therapist and/or Certified Occupational Therapist Assistant, Psychologist and Behavioral Health, a patient gives the therapist permission and authority to care for the patient in accordance with the evaluation and therapy procedures. The therapist, of course, will not give any treatment or health care if she is aware that such care may be contradicted. The SLP/PT/PTA/OT/COTA/LCSW/LPC/PhD provides a specialized, non-duplicating health care service. Your therapist is licensed in a special practice and is available to work with other types of providers in your health care regime.

Speech and Beyond uses treatment rooms for therapy. It is possible that one's treatment/therapy session and/or name may incidentally be observed and the possibility that conversations and/or names may incidentally be overheard are terms and conditions that the patient agrees to in this office. Speech and Beyond tries to limit incidental disclosures as much as possible and adhere to minimum necessary and reasonable safeguard requirements as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Speech and Beyond respects your privacy, so a private room is available for conversations if needed. Assorted notes/therapy information paperwork might be handed to you to fill out. It is your responsibility to guard these as you see fit while they are in your possession.

I understand that if I am accepted as a patient by a therapist at **Speech and Beyond, LLC**, I am authorizing them to proceed with any treatment that maybe necessary. Furthermore, any risk involved regarding speech, physical, occupational therapy, psychology, or behavioral health will be explained to me upon my request.

I _____ authorize Speech and Beyond, LLC
(Legal Guardian, Please Print)

to evaluate _____ and/or provide
(Patient Name, Please Print)
Speech, Occupational, Physical Therapy, Nutrition Counseling, Psychology, or Behavioral Health.

Patient or Guardian (If minor) Signature:_____

Date:_____

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Consent to Bill

I hereby authorize Speech and Beyond to bill my insurance company for direct reimbursement of therapy services rendered to my child. Unless otherwise noted, benefit payment will be assigned directly to Speech and Beyond. I understand that patient/patient's family is responsible to pay all fees accrued, regardless of insurance verification or anticipated insurance coverage, if insurance company refuses to pay provider a portion of the fees or in full. I agree to pay all fees within **30** days after bill has been mailed. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated banking, legal, and/or collection fees.

I understand that I am ultimately responsible for payment of all services received. I understand that I am advised to fully know and understand my insurance benefits prior to my child receiving therapy services. I understand that all insurance plans are different and it is impossible for Speech and Beyond to know the specifics of my plan and/or if my plan will reimburse for services received. Regardless of insurance verification or anticipated insurance coverage, I agree to pay all fees accrued for services received. Parent Initials_____

Consent for Play

I am aware that gross motor play is often encouraged during therapy. Use of swinging, running, climbing, and jumping assist with a variety of skills and performance components the therapists may need to address. I consent to use of gross motor play and exempt my child, therapist(s) and employee(s) and owner(s) of Speech and Beyond, from any injury resulting from this type of play. Parent Initials_____

For the protection and health of your child and our therapists, we do not change diapers. We do provide a changing table and wipes for your convenience. Parent Initials_____

Cancellation Policy

Please arrive on time for your scheduled appointment. If the client is receiving services in another setting, our therapists will make every effort to arrive on time. If you are going to be late, please call to notify us. Please understand that if you are late to an appointment, you may receive a shortened therapy session. Your appointment will be marked as a "no show" if we do not receive notice 24 hours in advance. Same day cancellations will be charged a $30 cancellation fee per day. After three "no show" appointments, you will be removed from our schedule and placed on a "call" list. When another client cancels, you will be offered that therapy time slot.

Parent/Guardian Signature:_____

Parent/Guardian Printed Name:_____

Client Name: _____ Date:_____

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CONSENT TO TREAT/RELEASE INFORMATION

In the event I am unable to bring my child to his/her scheduled appointment, I authorize Speech and Beyond, LLC to communicate with the following individuals about my child's therapy, progress, and/or plan of care.

Name	Address	Relationship to client
Name	Address	Relationship to client
Name	Address	Relationship to client

Client Name Parent/Guardian Name

Parent/Guardian Signature Date