



## Consent For Services

I, \_\_\_\_\_, give permission to Playworks Speech Therapy, PLLC, to exchange information with the following physicians, programs, or other persons:

\_\_\_\_\_

about \_\_\_\_\_, whose date of birth is \_\_\_\_\_.

I also give permission for Playworks Speech Therapy, LLC, to provide evaluations, treatment, and consultative services to the above- mentioned client.

I understand that Playworks Speech Therapy will not share information regarding the above- mentioned client with any individuals not listed on this form and all medical records, treatment notes, and other individually identifiable health information will be kept properly confidential.

## Fees

I understand that the fee for 50 minutes of speech/language therapy is \$140.00 until 12/31/2018. As of 1/1/2019, the fee for 50 minutes of therapy is \$145.00. I also understand that I will be charged at the time of service. **Reports, treatment plans, progress notes, and assessments are charged at the same hourly rate.** I understand that if I do not provide a credit card number, payment is due at the time of service.

I understand that health insurance policies and reimbursement are between myself and my health insurance company, that all services rendered by Playworks Speech Therapy, LLC, for the benefit of the above referenced individual, are charged directly to me, and that I am personally responsible for payment, in full, to Playworks Speech therapy, LLC, within ten days of the invoice date.

## Cancellation Policy

**I understand that cancellations made less than 24 hours in advance are billed at the rate of service except for emergency situations/illness.**

## Tricare

I understand that all services covered by Tricare, Humana, will be billed directly to Humana. I am responsible for services NOT COVERED by Tricare and all co-pays. I will renew the referral for Playworks Speech through my child's primary physician every 365 days.

Sponsor's Name: \_\_\_\_\_

Sponsor's Social Security Number: \_\_\_\_\_

If the social security number is not provided, Tricare will not be charged directly, and therefore I will be responsible for all charges.

## Video Policy

In an effort to provide accurate baseline data, comprehensive progress notes, and parent training opportunities, Playworks Speech will occasionally take video clips of my child in therapy. These videos will only be viewed by my child's therapist and clinical supervisors with Playworks Speech Therapy. By initialing here, \_\_\_\_\_, I am providing consent for Playworks staff to take video clips of my child.

\_\_\_\_\_

Signature of parent/guardian

\_\_\_\_\_

Date