Consent For Services Form

I, _____, give permission to *Speech For Each, LLC* to exchange information about _____, whose date of birth is ___/___/___, with the following physicians, programs, or other persons:

1.
2.
3.
4.

I also give permission for *Speech For Each, LLC* to provide evaluations, treatment, and consultative services to the aforementioned client.

I understand that *Speech For Each, LLC* 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 and Payment

- I understand that the fee for 45 minutes of direct individual speech/language therapy (with 15 minutes for parent/teacher discussion and homework review) is $160.00.
- I understand that the fee for 45 minutes of direct group speech/language therapy (with 15 minutes for parent/teacher discussion and homework review) is $125.00 per child.
- All written reports are billed at a rate of $160.00 per hour, as are scheduled/formal phone conferences and professional or team meetings, such as IEP and Child Find meetings.

I understand that I will be charged at the time of service. Payment options include credit card (preferred), cash, or check, made payable to *Speech For Each, LLC*. I understand that health insurance policies and reimbursement are between myself and my health insurance provider, that all services rendered by *Speech For Each, 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 *Speech For Each, LLC* at the time of service.

Cancellation Policy

I understand that cancellations made less than 24 hours in advance are billed at the rate of service except for emergency situations or sudden-onset illness. A make up session can be scheduled within two weeks of a canceled session as an option to offset this charge; however, make up sessions are **not** guaranteed. If a make up session is not or cannot be scheduled, I understand that I will be charged at the rate of service for the missed session and that I am personally responsible for payment, in full, to *Speech For Each, LLC* at the time of the next session.

I understand that I can terminate services at any time, with or without the recommendation of my therapist. I understand that if I wish to terminate services for any reason, I must provide two full weeks of notice in writing. Furthermore, I understand that if I wish to terminate services *immediately* for any reason, I will be billed for any and all sessions previously scheduled for the two weeks following my written notice.

Signature of parent/guardian/individual: _____

Date: ___/___/___