HELP ME SPEAK, LLC
Barbara A Taylor, M.S., CCC-SLP, COM™
& Associates
2500 Wallington Way; Suite 103
Marriottsville, MD 21104
410-442-9791

Dear Client,

Welcome to Help Me Speak! We look forward to meeting you at the initial evaluation.

We've scheduled an evaluation session on (**Monday/Tuesday/Wednesday/Thursday), _____ (date) at _____ (time)**. Also, please complete the enclosed forms and send or bring the following information:

- Any previous evaluation reports by physicians, therapists, & teachers within the past 6 months to one year
- A list of all medications/supplements that are taken regularly.
- The names, addresses and phone numbers of any therapists and doctors with whom you desire HMS to share information
- Your insurance card, your driver`s license/ID card and/or driver's license of guardian.

Return the above information and enclosed forms to Help Me Speak (HMS) at the address above so that we may receive them ***7 days prior*** to the evaluation day. You may also fax them to us at 410-442-9783.

When you come to the evaluation, please bring the following items that you typically enjoys*:

- The dish, cup & utensils that you normally uses (if different from standard ones)
- A **liquid** that you typically drink such as fruit juice or milk
- A **semi-solid** such as applesauce, yogurt or pudding
- A **soft solid** such as a banana, canned fruit, or *cubed* cheese
- A **hard solid** such as carrot sticks or apple wedges
- A **crunchy solid** such as pretzel rods, tortilla chips
- A **chewy solid** such as fruit snacks, a bagel, or meat

*If you do not enjoy a type of food listed, please bring an example of it, which you *may* try.

Please keep in mind that careful planning and preparation (including record review) goes into your evaluation to determine your needs and strengths.

In the event that you need to reschedule your ***evaluation***, **72-hour notice is required**. There is a **$100.00 fee** for less than 72-hour cancellation notice, for last minute/no-shows, or for rescheduling of >1 time. We regret that we must implement this policy, but it has become necessary. Exceptions may be made to this policy in rare, extenuating circumstance with the permission of the CEO of Help Me Speak.
Please read and sign the attached evaluation reservation form. The fee will be charged to the credit card #, which you provided to our office upon registration.

Since HMS' SLPs sit in close proximity to you and often are working on oral swallowing with the jaw, lips, cheeks, and tongue, we are much more susceptible to catching a contagious illness. In accordance with the HMS Illness policy, we ask you, our clients, to respect our SLPs, our staff & our own families and other HMS clients & families. ***Please contact the office to reschedule your therapy session as soon as you become sick or by 9:00 am on the day of the appointment*** if you have been ill with any of the following symptoms within the 72 hours prior to the session (evaluation or therapy):

1. ***You need to be vomit/diarrhea free for 72 hours before your evaluation/therapy session***.

http://www.cdc.gov/norovirus/about/symptoms.html

· a temperature of 100.4 or above
· sore/strep throat (&/or severely red throat)
· vomiting (contagious for 72 hours after illness too)
· coughing
· contagious infection for which you have not started antibiotics (sinus infection, pink eye, flu, cold, severe coughing, etc.)
· discolored mucous (yellow or green)
· influenza
· any other contagious symptom

2. If you have exhibited any of the other contagious symptoms, you must be symptom free for 24-72 hours prior to your session. In the event that you need to reschedule your weekly **therapy session**, **advance notice is required**. Please keep in mind that careful planning and preparation goes into each therapy session to maximize progress and potential. Also, there is a waiting list for current slots. We encourage our clients to attend all of their scheduled sessions (1x, 2x, or more per week) so that you can receive full benefit from your therapy plan. Therapy sessions should be rescheduled if needed due to illness or other unexpected conflicts. This means that you may have one extra session that week, in addition to the regular sessions. Make up sessions are allowed for all but no show sessions. ***Please contact the office to receive a response as soon as possible or by 9 am on the day of your session if you need to reschedule.*** **Any session not rescheduled by 9 am on the day of the appointment or a no show session will be charged at the full session fee**. This fee is not eligible to be submitted to or reimbursed by insurance.

Please read and sign the attached letter for more information on make-up sessions. The fee for missed appointments must be collected prior to (or at) your next scheduled appointment.

Directions to our Help Me Speak office are attached. We have a waiting area and invite you to **arrive a few minutes early** so that you will have time to review our policies. We look forward to meeting you and you. Please call us with any questions at (410) 442-9791.

Sincerely,
Barbara A Taylor

Barbara A Taylor, M.S., CCC-SLP, COM™
Speech-Language Pathologist
Certified Orofacial Myologist
CEO, HELP ME SPEAK, LLC

HELP ME SPEAK, LLC
2500 Wallington Way; Suite 103
Marriottsville, MD 21104
410-442-9791

Directions to the HELP ME SPEAK office location:

From Columbia Mall area/Rt 108:
take Harper's Farm Rd across Rt 108-→ it becomes Homewood Rd.
continue on Homewood Rd until you reach the circle/roundabout in the road
go1/4 to the right and turn right onto Folley Quarter Rd
go to end of Folley Quarter Rd
turn left onto Rt 144
continue on Rt 144 until Marriottsville Rd on right
turn RIGHT onto Marriottsville Rd
cross Rt 40, cross over I-70
Make a RIGHT at the 1st traffic light→ Warwick Way (just past blue silo bldgs)
Make an immediate RIGHT to the professional buildings on **Wallington Way**
We are on the **LEFT** (the building up the hill/behind the blue silos)
Park on your LEFT in any of the available spaces
Our suite is # 103

From Rt 32:
take Rt 32 West to I-70
take I-70 East (very short distance)
take the Rt 40 EXIT
turn LEFT at the light for Marriottsville Rd
cross over I-70
continue as in #9 above

From Rt 29:
Rt 29 North to I-70 West (take either the left or right hand exits from Rt29)
I-70 West to the first exit at Marriottsville Rd.
There is only ONE exit. On the exit ramp, bear Right onto Marriottsville Rd.
Continue as in #9 above

From points west:
I-70 East to Rt 40 EXIT
Turn LEFT at the light for Marriottsville Rd
Cross over I-70
Continue as in #9 above

From points east:
695 West to I-70 West
I-70 West, past Rt 29 exits
To Marriottsville Rd exit
There is only ONE exit. On the exit ramp, bear Right onto Marriottsville Rd.
Continue as in #9 above

From points north of Marriottsville Rd (Owings Mills, Reisterstown, etc.)
Drive to Marriottsville Rd & go South
Crossover Rt 99 at the light, continue south
At the next light, turn Left onto Warwick Way (brick building w/silos faces road)
Continue as in #10 above

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Evaluation Agreement

I, _____, understand that the cash/private pay rate for this evaluation (speech/oral-motor/eating language other :to be determined) ranges up to $ 695.00 for the Evaluation. I understand and agree that my copay $_____, the co-insurance amount listed on the EOB (Explanation of Benefits), a portion of my deductible, per my insurance, &/or the balance for services not covered by my insurance, is my responsibility. I understand that the contracted insurance rate, per CPT code, is different than this cash rate. I understand that my copay is **due at the time of service** and that my co-insurance &/or amount towards my deductible is **due at the start of my next session** *after HMS' receipt of the EOB.*

My insurance company is:

- □ Carefirst (BC/BS) Group# _____ID#_____
- □ Cigna Group# _____ID#_____ OON Benefits ____Y____ N
- □ United Healthcare Group# _____ID#_____ OON Benefits ____Y____ N
- □ Aetna Group# _____ID#_____ OON Benefits ____Y____ N
- □ JH US Family HC Group#_____ ID#_____ OON Benefits ____Y____ N
- □ Medicaid Group#_____ ID#_____ OON Benefits ____Y____ N
- □ Evergreen Group#_____ ID#_____ OON Benefits ____Y____ N
- □ _____ Group#_____ ID#_____ OON Benefits ____Y____ N

_____My yearly deductible is $_____ I have met $_____ of my deductible and have a remaining balance of $_____.

_____I have a copay of $_____ per session or co-insurance of $_____ per session. My co-insurance may vary depending of what is charged per session.

_____My insurance requires a pre-authorization for speech/language sessions. Pre-authorization is normally submitted after the Evaluation is completed. Pre-authorization has been ____approved, approval code is _____ for _____sessions or pre-authorization has been____ denied.

Help Me Speak is in-network with all CareFirst/BCBS, Kaiser and pediatric Medicaid plans. Your insurance company sets the CPT (current procedure code) fee schedule that determines what they allow for each CPT, dependent on my specific plan.

If you do not have a Blue Cross Blue Shield (Carefirst), a Kaiser or a pediatric Medicaid plan, please check your insurance plan to see if you have ***out-of-network*** coverage for speech/oral motor/swallowing evaluation services. If requested, Help Me Speak will provide you with an invoice for each visit in a monthly billing statement for your records. It will be your responsibility to pursue insurance reimbursement for out of network services that may be covered OR we can submit on your behalf, to your insurance for reimbursement to you.

If HMS is not a preferred provider with my insurance, full payment is ***due at time of service***. Payment may be made by check, cash, or credit card (American Express, Visa, MC, and Discover). This fee is non-negotiable and non-refundable after the service is rendered. Failure to pay at the time of service will result in a $25 *per week* late charge.

The client understands that Help Me Speak will make every effort to ensure a complete and thorough evaluation in the areas requested. Certain evaluation techniques require cooperation and participation from the client to accurately assess the client's skills. The client understands that Help Me Speak will not be held responsible for a fully completed evaluation if the client refuses to cooperate during the evaluation session(s) even after all reasonable attempts have been made to engage you. In such cases, either Help Me Speak or the client has the right to end the evaluation session early as needed and to reschedule the remainder for a follow-up session.

Help Me Speak speech-language pathologists must abide by ethical practices from their Professional Boards that forbid the guarantee of any specific evaluation results for any client.

By signing below, I acknowledge that I have read and understand this evaluation agreement and will fully abide by all of the terms stated above and am consenting to treatment.

_____	_____	_____
Initial	Date	Client Name/Guardian

Therapy Cancellation Policy

Our highest priority is your progress. To ensure continuity of care and continued progress on Plan of Care goals, HMS requires our clients to maintain **80% or greater monthly attendance** in order to *keep your session in the weekly schedule*. **Excessive cancellations of more than 25% of scheduled sessions during any 30 day time period will result in D/C from active therapy.** If you have ***3*** *no shows* you will be *discharged* from active therapy.

Please remember that careful individual planning and time goes into preparing for your speech-language therapy. We aim to maximize your potential and progress with consistent therapy sessions. Consistent attendance is essential to achieving speech-language goals and so that each client can receive full benefit from his/her therapy plan. For this reason, we strongly encourage our clients to attend all scheduled therapy sessions and for any cancellations to be rescheduled. This make up will be in addition to the regularly scheduled frequency of therapy (e.g. client may have 2 sessions in one week). Make up sessions are available for all but *no show* sessions (a session in which notice is not given for the absence).

If you need to reschedule a session (for any reason, including illness), please give as much notice as possible. Please **call** (**410-442-9791**), **email** (office@helpmespeak.com) or **text** the HMS office via **Google #** (**443-212-8523)** (**text only**, no calls) before **9:00 am** on the day of your scheduled session. We will reschedule your missed session within the same week or the following week. **Any session not cancelled by 9:00 am on the day of the scheduled appointment or a no show session will be charged the full session fee**. No show sessions are ***not*** available for make-ups. If you make up a late cancelled (< 4hrs) session within 7 days, no cancellation fee will be charged. The session will be billed as usual. When rescheduling, we will look first on the same SLP's schedule, then on our other appropriate SLPs' schedules. If no make ups are available then the full fee is due.

Since HMS' SLPs sit in close proximity to you and often are working on oral swallowing with the jaw, lips, cheeks, and tongue, we are much more susceptible to catching a contagious illness. In accordance with the HMS Illness policy, we ask you, our clients, to respect our SLPs, our staff & our own families and other HMS clients & families. ***Please contact the office and receive a response to reschedule your therapy session as soon as you become sick or by 9:00 am on the day of the appointment*** if you have been ill with any of the following symptoms within the 72 hours prior to the session (evaluation or therapy):

1. ***You need to be vomit/diarrhea free for 72 hours before your therapy session.***

http://www.cdc.gov/norovirus/about/symptoms.html

· a temperature of 100.4 or above
· sore/strep throat (&/or severely red throat)
· vomiting
· coughing
· contagious infection for which he/she has not started antibiotics (sinus infection, pink eye, flu, cold, severe coughing, etc.)
· discolored mucous (yellow or green)
· influenza
· any other contagious symptom

2. If you have exhibited any of the other contagious symptoms, you must be symptom free for 24 hours prior to your session. In the event that you need to reschedule your weekly **therapy session**, **advance notice is required**. Please keep in mind that careful planning and preparation goes into each therapy session to maximize progress and potential. Also, there is a waiting list for current slots. We encourage our clients to attend all of their scheduled sessions (1x, 2x, or more per week) so that he/she can receive full benefit from their therapy plan. Therapy sessions should be rescheduled if needed due to illness or other unexpected conflicts. This means that you may have one extra session that week, in addition to the regular sessions. Make up sessions are allowed for all but no show sessions. ***Please contact the office to receive a response as soon as possible or by 9 am on the day of your session if you need to reschedule.*** **Any session not rescheduled by 9 am on the day of the appointment or a no show session will be charged at the full session fee**. This fee is not eligible to be submitted to or reimbursed by insurance.

Please read and sign below for more information on make-up sessions. The fee for missed appointments must be collected prior to (or at) your next scheduled appointment.

I _____, understand that if I miss a session and have not called: 410-442-9791, texted (443)212-8523, or emailed office@helpmespeak, before 9:00 am prior to my session time to cancel, I will be charged for the session in full. I am responsible for confirming HMS' receipt of my cancellation/reschedule request. This fee is not covered by, or submitted to, my insurance company. The fee for a missed appointment will be collected prior to (or at) my next scheduled appointment. I understand that I am strongly encouraged to reschedule my session ASAP for continued progress on my treatment plan.

_____ _____ _____

Client Name Client/Guardian Signature Date

Therapy Session Schedule

Please remember that careful individual planning and time goes into preparing for your speech-language therapy. We aim to maximize your potential and progress with consistent therapy sessions. ***Therefore your schedule will be on the same dates and times each week for consistency.***

_____ _____ _____

Client Name Client/Guardian Signature Date

Therapy Schedule Change or Cancellation

If I need to change my therapy session day or time, I will give HMS at least 10 days notice of this change. If we decide to cease therapy services, we will notify HMS at least 10 days in advance.

_____ _____ _____

Initials Date Client/Guardian Signature

Therapy Tools

Please remember that careful individual planning and time goes into preparing for your speech-language therapy. Therefore we require you to bring the therapy tools to each session. As a courtesy we will provide/lend clients the first tool of its kind to assist the client with their exercises. ***If the tools are lost/misplaced there will be a charge for each tool of $1.00 excluding Bite Blocks. Bite Blocks will be charge the full replacement cost of $29.95.***

_____	_____	_____
Client Name	Client/Guardian Signature	Date

Damages

I am financially responsible for any breakage or damage by myself, siblings, friends and relatives to any item (toys, therapy equipment/tools, office space, etc.) within this office.

For Example: Session Monitor - $100.00 (for a replacement monitor)

Payment for any items damaged will be required prior to (or at) my next therapy session. I accept full financial responsibility for any damage by myself, _____, to any therapy/office item. Payment for items damaged is required prior to (or at) my next scheduled therapy session.

_____	_____	_____
Client Name	Client/Guardian Signature	Date

Therapy Agreement

I, _____, understand that the cash rate varies (ask for rates) or my copay $_____ which is *due at the time of service to Help Me Speak*. I understand and agree that my copay $_____, the co-insurance amount listed on the EOB (Explanation of Benefits), a portion of my deductible, per my insurance, **&/or** the balance for services not covered by my insurance, is *my responsibility*. I understand that the contracted insurance rate, per CPT code, is different than HMS' cash rate. I understand that my copay is **due at the time of service** and that my co-insurance &/or amount towards my deductible is **due at the start of my next session** *after HMS' receipt of the EOB.*

Payment may be made by check, cash, or credit card (American Express, Visa, MC, and Discover). This fee is non-negotiable and non-refundable after the service is rendered. Failure to pay at the time of service will result in a $10 *per week* late charge.

I understand that the therapy session(s) will be planned and will be individualized in accordance with the results of your evaluation. Therapy sessions utilize a variety of techniques and modalities (which may include structured oral motor hierarchies, stretches, PROMPT, Kaufman cards, Lindamood Bell, etc.) as appropriate to each your needs, which are selected by the speech-language Pathologist (SLP). Scheduled appointment times are adhered to.

Treatment sessions do not run over their allotted time. If the client is late (less than 10 minutes), the session will still end at its regularly scheduled time and be billed at the regular rate. If the client is over 10 minutes late, it will be at the discretion of the SLP and Office Manager if the you will be seen. If the you are not seen, you may be charged with a late fee/no show fee of $100.00. The charge for each therapy session includes the SLP's direct, actual time working with the client, the consultation time with the client reviewing the goals of the treatment session and progress toward goal attainment, AND the coordination of care time including explaining any reasons for recommended for diagnostic testing, the procedure results, the SLP's impression/interpretation of these results, &/or further recommended diagnostic testing, the risks &/or benefits of treatment/therapy options; the instructions for treatment or follow up, the importance of compliance with SLP recommended treatment options.

The client understands that homework assignments are a ***vital*** component of the total therapy program and agree to participate as prescribed by the SLP. Exercises and tasks given for homework will be reviewed with the client. Help Me Speak aims to give homework elements that are emerging during therapy sessions and that will not elicit frustration for either the client during practice. Homework programs are typically prescribed 1-3x/day for 3-5x/week. The client, understand the importance of *consistent* weekly participation in the recommended homework plan. Lack of participation in or decreased consistency with the homework plan by the client may impact the client's overall amount and rate of progress. Help Me Speak is not liable for lack of progress, a reduced rate of progress, or a reduced amount of progress if the client has not been fully participating with the homework plan.

Help Me Speak speech-language pathologists must abide by ethical practices from their Professional Boards that forbid the guarantee of any specific progress results for any client.

By signing below, I acknowledge that I have read and understand this therapy agreement, will fully abide by all of the terms stated above and am consenting to therapy.

_____	_____	_____
Initials	Date	Client/Guardian Signature

Sessions Include:

The client understands that the therapy session(s) will be planned and will be individualized in accordance with the results of your evaluation results. Therapy sessions utilize a variety of techniques and modalities (which may include structured oral motor hierarchies, stretches, PROMPT, Kaufman cards, Lindamood Bell, etc.) as appropriate to each your needs, which are selected by the speech-language Pathologist (SLP). Scheduled appointment times are adhered to. Treatment sessions do not run over their allotted time. If the client is late (less than 10 minutes), the session will still end at its regularly scheduled time and be billed at the regular rate. If the client is over 10 minutes late, it will be at the discretion of the SLP and Office Manager if the you will be seen. If you are not seen, you may be charged with a late fee/no show fee of $100. The charge for each therapy session includes the SLP's ***direct, actual time working with the client, the consultation time with the client/any caregivers to review the goals of the treatment session and progress toward goal attainment, AND the coordination of care time including explaining any reasons for recommended for diagnostic testing, the procedure results, the SLP's impression/interpretation of these results, &/or further recommended diagnostic testing, the risks &/or benefits of treatment/therapy options; the instructions for treatment or follow up, the importance of compliance with SLP recommended treatment options.***

The client understands that homework assignments are a ***vital*** component of the total therapy program and agree to participate as prescribed by the SLP. Exercises and tasks given for homework will be reviewed with the client.

_____ _____ _____

Initials Date Client/Guardian Signature

Communication

I agree to be available for communication with my SLP before/during/after each session, as appropriate. I will ask questions about any therapy information, activity, or goal as needed. If I have a question, concern, or comment, I will relay this to my SLP or HMS' CEO in person or via email or phone. If I am considering a change in my services, I will discuss these with my SLP or HMS prior to rendering my decision.

_____ _____

Client's Name Client/Guardian Signature

Check Return Policy

There will be a $25.00 charge for all returned checks for non-sufficient funds. The sum of the original check plus the $25.00 NSF charge must be received prior to any further visits.
By signing you are agreeing to the above terms.

_____ _____

Client's Name Client/Guardian Signature

Authorization to use Voice, Image and Likeness

I hereby authorize you to videotaped, photographed, and/or audio taped during any therapy activity (evaluation, session, group, class or event) at Help Me Speak. As a client participating in any therapy at Help Me Speak, I hereby agree that Help Me Speak may make video, photo, &/or audio recordings of my voice, image and/or likeness. I further understand that Help Me Speak preserves such videotapes, photos, and audiotapes for its own use for the benefit of Educational training, marketing and advertising and is in compliance pursuant to 45 CFR 164.524(c) (4) (HIPAA). I acknowledge that the rights to any such recording belong solely to Help Me Speak and I make no claim to any rights in such recordings. To the extent necessary, I assign any copyright or other right which I may have in my action as captured on such video and audio tape fully, completely and without royalty to Help Me Speak.

- □ I do not authorize Help Me Speak to use video, photo, &/or audio recordings of my voice, image and/or likeness in any advertisement or on the internet. The video, photo, &/or audio recordings of my voice, image and/or likeness will only be used for evaluation and therapy purposes.

_____ _____

Client/Guardian Signature Date

I acknowledge that **I may videotape** during a Help Me Speak session ***ONLY after the prior approval of the owner/CEO, Barbara A Taylor***. A copy of any such approved recording needs to be emailed to: office@helpmespeak.com or a DVD copy may be given to HMS. I agree to use this video solely for the purpose of client/immediate family education. I agree **NOT** to post this video to any websites, social media sites, show it to any other professional UNLESS previously approved in writing by Help Me Speaks` owner/CEO.

_____ _____

Client/Guardian Signature Date

Waiting Room Policy

Please refrain from eating messy foods and drinking messy beverages in our waiting room. Any spills are your responsibility and you will be charged accordingly. ***Water and dry snacks only*** are allowed in the waiting room. Also, please **NO PEANUT** or **NUT** products in the waiting room due to potential allergies of other clients.

Thank you for your cooperation and understanding.

☐ I understand & promise to abide by the above waiting room policy.

_____ _____

Client/Guardian Signature Date

Observation Policy

Help Me Speak values family participation and observation of your session. Since family training and communication is such an integral part of each session, we do *not* allow the family to "drop off" the client for a therapy session without discussing with your SLP first.

Help Me Speak and your SLP are not responsible or liable for client and it is unsafe for client to be unattended after the session is completed. We require that guardian(s) be present in the office during the entire session. Family/guardian(s) may observe from the waiting room via a monitor, in an adjacent unoccupied treatment room, or in the room, with the agreement of your SLP.

I understand that HMS may, at times, have other professionals who would like to observe my session. These professionals abide by HMS's Confidentiality Policy. I understand that I have the right to deny any observation requested. Thank you for your cooperation and understanding.

I understand & promise to abide by the above Observation Policy.

_____ _____

Client/Guardian Signature Date

Medical Attention

I, _____, agree that in the event I am involved in an incident that requires medical attention, the undersigned will be responsible for making the all the decisions related to all medical and survival procedures for the client while the client is enrolled in the program, including, but not limited to, the decisions about medical care, the administration of drugs, and the performance of any and all life sustaining procedures. The undersigned further agrees to make any and all arrangements for the client's transportation and admittance to any hospital, health center, or medical clinic in the event of an emergency situation involving the client. In the event that the guardian or emergency contact cannot be reached during the medical emergency, the undersigned gives Help Me Speak permission to make decisions regarding any and all medical and survival procedures for the client. The undersigned agrees that Help Me Speak, its owners, employees, contractors, volunteers, and staff will not be held responsible for any accident or losses, however caused.

_____ _____

Client/Guardian Signature Date

Release of Liability

The undersigned waives any and all claims or actions that may arise against Help Me Speak, as well as its owners, employees, contractors, volunteers and staff as a result of any injury, loss, theft, or damage to any such person, including and without limitations, personal, bodily or mental injury, economic loss or any damage to the client. The undersigned agrees to defend, indemnify and hold Help Me Speak harmless against any claim (including reasonable attorneys' fees) arising out or resulting from acts or omissions of the client or me or the breach by me or the participant of this Agreement.

I am the client or legal guardian(s) of the above referenced client and I hereby certify that I have read and understand this entire Agreement and agree to and accept its terms and conditions. I further agree that the client will abide by all rules and policies of Help Me Speak, which are subject to change and which, in the opinion of Help Me Speak, are deemed necessary and reasonable for the best interests of the clients of Help Me Speak, sessions. Finally, no client will be admitted to Help Me Speak sessions without this Agreement form completed in its entirety.

_____ _____

Client/Guardian signature Date

HIPAA Information Practices & Privacy Statement

My signature on this form acknowledges that I have reviewed, understand, and agree to the HIPAA private policy practices of Help Me Speak. The Information Practices & privacy statement is located in the binder in the waiting room. Copies are available upon request.

_____ _____ _____

Client/Guardian Signature Print Client Name Date

RELEASE OF INFORMATION

Client's name: _____

I give my permission for Help Me Speak **to release information to and to receive information** regarding my speech-language assessment and/or treatment results from the following individuals: (e.g. organizations/client's doctor, etc.)

_____	_____
Primary Doctor's Name	Address/Phone Number/email
_____	_____
Other Doctor's Name	Address/Phone Number/email
_____	_____
Dentist/Orthodontic Contact Name	Address/Phone Number/email
_____	_____
Other	Address/Phone Number/email
_____	_____
Other	Address/Phone Number/email
_____	_____
Other	Address/Phone Number/email
_____	_____
Other	Address/Phone Number/email
_____	_____
Client/Guardian Signature	Relationship to client

_____

Date

Client Registration

Date: _____ Client's Name: _____

Date of Birth: _____ Age: _____

Responsible Party:_____ (Relationship): _____

Address: _____ Email: _____

Client

_____

_____

Home Phone: _____ Client's Cell Phone: _____

Occupation: _____

Work Phone: _____

Employer/Address:

_____

_____

Primary Care Physician/Address/Phone: _____

_____

_____

Diagnosis (Reason for Treatment): _____
Onset Date: _____

Professional who made above diagnosis: _____
Professional Credentials (type): _____

I certify that the above information is true. I will notify Help Me Speak of any changes to the above information.

_____ _____

Print Client's Name

Client's Signature or Responsible Party