

Barbara A. Taylor, M.S., CCC-SLP, COM® & Associates 410-442-9791

www.helpmespeak.com office@helpmespeak.com

12/2018

I hereby authorize Help Me Speak, to directly receive payment of pertinent insurance benefits; to release information including protected health information (TPO) to insurance companies and other related third parties as needed in relation to the filing for or collection of payment for provided services; to obtain records from other sources as needed in relation to patient diagnosis and treatment; and to convey information through various means as needed in accordance with the Notice of Privacy Practices, a copy of which was made available to me.

I hereby acknowledge that I am personally responsible for all co-payments, deductibles, co-insurances, non-covered services and required referrals according to my insurance policy. I agree to pay all applicable charges accrued and to promptly pay any balance in full. If my insurance does not pay within 120 days, I understand that I will be held personally responsible for any balance. I understand that my account will be charged \$25.00 for any checks returned due to non-sufficient funds. I agree to promptly alert Help Me Speak should there be any changes related to insurance and other information I provided above.

With my consent, Help Me Speak may email (_______) &/or call/contact my

home or other designated lo	ocation listed below:	,
		<mark>#</mark>),
and leave a message on voic	cemail or in person in reference	to any items that assist the practice in carrying out TPO, ms, and any call pertaining to clinical care including test
•	ppointment reminder cards, pat	other designated location any items that assist them in items statements, and test results as long as they are
Name and Signature of Res	sponsible Party:	
		Date:
Barbara A Taylor, M.S., CC		Reviewed by:
	st, Certified Orofacial Myologis	_
Owner/ Director, HELP M	LE SPEAK, LLC	Date: