Patient Consent and Authorization Form

1. I authorize Speech Pathology Solutions, LLC, Inc. to render appropriate therapy services to _________________________. I understand that care will be provided by an appropriately trained health care professional. I recognize and agree that I have the right to refuse treatment or terminate services at any time. In addition, Speech Pathology Solutions, LLC may terminate services by notifying me of termination. I hereby authorize Speech Pathology Solutions, LLC to bill any insurer identified by me and allow for the release of any information necessary to process claims for medical benefits.

2. I consent and agree that Speech Pathology Solutions, LLC and its staff may contact me, leave voice messages, send me text messages and/or send me emails to the phone number(s) and email address(es) I have provided them. I understand that these messages can include protected health information, such as patient name, appointment information, billing information, information that identifies the practice as a speech therapy practice, and my pertinent clinical information. I understand that text messages and emails are not secure forms of communication and the by consenting to these communication types, I am waiving my rights to secure electronic communication. ___ I do NOT want to receive messages, text messages or emails that contain protected health information.

3. I hereby authorize and request tat copies of my prior medical records related to speech-language pathology evaluation or treatment services be delivered to Speech Pathology Solutions, LLC to establish or continue my health care treatment plan. This included the complete assessment, most recent plan of treatment, progress summary, treatment notes and any other appropriately related documents or information.

Patient/Authorized Representative SIGNATURE

I have read and fully understand the content of this consent and authorization release, and hereby agree to and authorize the foregoing provisions. As used in this document, the terms “I”, “me” and “my” refer to and include, in addition to the undersigned, the patient named above and other for whom the undersigned is responsible or for whom the undersigned has assumed responsibility engaging in Speech Pathology Solutions, LLC to provide services to the patient. This consent and authorization is valid until revoked by me in writing.

____ Date: ______________

Printed Name: ____

Relationship to Patient: ____