



Consent to Speech Therapy Services

I hereby consent and authorize Speech EZ, LLC to evaluate, diagnose, and provide speech and language therapy OR myofunctional therapy for:

_____.

Financial Policy

Thank you for choosing Speech EZ, LLC! Please note that Speech EZ, LLC is currently a private pay-only practice and does not directly accept or work directly with insurance companies. We will however provide documentation (i.e., super bill) when requested for reimbursement by your insurance. Clients are responsible for confirming insurance coverage and handling all communications/transactions with the insurance company. If a superbill is requested, all payment is directly paid to Speech EZ, LLC and you will receive a superbill to submit to insurance. Please note that all insurance companies vary and speech-language therapy services may or may not be covered by your insurance.

All payment for services is required at the time the service is rendered or on a monthly basis. Speech EZ, LLC accepts payment by cash or Zelle.

Prices and Fees

Speech EZ, LLC provides screenings/consultations prior to scheduling an assessment and therapy services to understand if services are warranted and to plan for the appropriate assessment. Consultations will take place online and the cost will go towards the evaluation visit. Evaluations can be completed in-person taking place in the client's home or online based on the recommendation of the evaluator. Weekly therapy can be completed online or in the client's home based on recommendation from evaluation. If therapy is conducted in the home within a 10-mile distance, the prices below include the driving fee. If beyond 10 miles, a driving fee of \$5-10 will be added to your invoice. Prices for assessments may vary depending on the type of assessment recommended and type of report desired.

Service	Price
Consultation/Screening (online) - 15-20 min	\$35 (goes toward evaluation)
Speech Evaluation (30-60 minutes)	\$200 includes report
Language Evaluation (60-90 minutes)	\$300 includes report
Orofacial Myofunctional Evaluation (30-60 minutes)	\$250 includes report

SPEECH EZ

Let's make speech easy!

Language and Speech Evaluation (90-120 minutes)	\$400 includes report
Speech and Orofacial Myofunctional Evaluation (60-90 minutes)	\$350 includes report
60 Minute Therapy	\$160
30 Minute Therapy	\$80

Acknowledgment of Financial Policy

I, _____, acknowledge and accept full and complete responsibility for payment of all services rendered by Speech EZ, LLC and/or its consultants. I understand that I am responsible for prompt payment of any cancellation or no show fees insured as outlined in the Attendance and Cancellation Policy. I have read, understand, and hereby agree to the Financial Policy of Speech EZ, LLC.

Signature: _____ Date: _____

Printed Name: _____

Name of Patient: _____

Relationship to Patient: _____



Descriptions of Assessments

1. **Speech Sound Assessment:** A licensed speech-language pathologist analyzes a client's speech sound production and ability to be understood utilizing standardized testing measures and natural language samples. The client may be asked to name pictures, answer questions, read a book, and imitate the therapist.
2. **Language Assessment:** A licensed speech-language pathologist analyzes a client's understanding and use of language utilizing standardized testing measures and natural language samples. Depending on your concerns, a language assessment may look at early language development, grammatical structures, communicative functions, syntax, and more.
3. **Orofacial Myofunctional Assessment:** A licensed speech-language pathologist with orofacial myofunctional training analyzes the client's oral resting posture, facial and oral structures, and labial and lingual functions that are foundational for speech, swallow, and at rest posture, and breathing mechanism. The therapist will assess the oral phase of the swallowing mechanism, as well as the client's speech sounds.



Attendance and Cancellation Policy

In order to better serve you and make quicker progress toward goals, regular attendance to therapy is imperative. Your child's success depends on consistent attendance.

Absences

Speech EZ, LLC breaks the year into four (4) attendance periods:

- January to March
- April to June
- July to September
- October to December

Two (2) absences are permitted per client. These absences account for vacations, doctors appointments, illness, etc. Any more than the two permitted absences must be rescheduled by the end of each attendance period, or you will be charged the full session fee. Speech EZ, LLC asks that you notify your therapist of a planned absence(s) at least 24 hours prior to your scheduled sessions. Absences do not carryover between attendance periods.

Rescheduling Visits

Speech EZ, LLC encourages you to reschedule any missed session(s) to maintain your child's progress. Rescheduling appointments will require flexibility on the part of your family and the therapist. We do not reschedule any previously rescheduled appointments.

To cancel or reschedule an appointment please email your therapist:

- Kelsey Timler CCC-SLP: kelsey.speechez@gmail.com
- Brandi Logan-Ochoa CCC-SLP: brandi.speechez@gmail.com

No-Shows & Late Cancellations

All no-shows and late cancellations will be charged the full session fee and can not be rescheduled. Any session canceled less than 24 hours in advance of the therapy session or evaluation is considered a late cancellation.

Punctuality

If you are late for an appointment your session will need to conclude at the regularly scheduled time. If you arrive more than 15 minutes late to your session, it will be considered a no-show.

Holidays

Our offices will be closed in observance of the following holidays. If you celebrate a religious holiday that is not listed here, please let your therapist know when you begin therapy - a maximum of two days per year will be allowed. Speech EZ, LLC will be closed on the following holidays: New Years' Day, Martin Luther King Jr Day, President's Day, Memorial Day,



Independence Day, Labor Day, Veterans Day, Thanksgiving & the day after, Christmas Eve, Christmas Day, and New Years' Eve.

Termination of Services

Speech EZ, LLC reserves the right to terminate services due to the behavior of a client or parent, delinquent billing, excessive absences, cancellations, or no shows. If you choose to withdraw your child from services, we require a two-week notice. You are responsible for attending all sessions during this time, using your two absences within a quarter, or paying the full session fee for the remaining appointments. We will work with you to reschedule the final sessions.

Signature: _____

Date: _____

Printed Name: _____

Name of patient: _____

Relationship to patient: _____

Release Form (optional)

Photographic Images

I give permission to Speech EZ, LLC to take and use photographic images for the following purposes (check all that apply):

- Trainings and/or educational purposes
- Use for marketing of Speech EZ, LLC (e.g., website, blog, brochures)
- Inclusion on the Speech EZ, LLC Facebook page or Instagram account

Audio Recordings

I give permission to Speech EZ, LLC to take and use audio recordings for the following purposes (check all that apply):

- Trainings and/or educational purposes
- Use for marketing of Speech EZ, LLC (e.g., website, blog)
- Speech EZ, LLC Facebook page or Instagram account

Video Recordings

I give permission to Speech EZ, LLC to take and use video recordings for the following purposes (check all that apply):

- Trainings and/or educational purposes
- Use for marketing materials of Speech EZ, LLC (e.g., website, blog)
- Inclusion on the Speech EZ, LLC Facebook page or Instagram account

Signature: _____ Date: _____

Printed Name: _____

Name of patient: _____

Relationship to patient: _____



Consent to Release of Information

I give permission for the staff of Speech EZ, LLC to exchange information about my child or self. This information includes their diagnosis and therapy plan in the following manners: phone call, virtual teleconferencing, email, or in-person meetings.

Please mark types of information that can be shared:

Evaluation Records Treatment Summary Visit Notes
 Medical Records Diagnosis

1. Pediatrician: _____
 - a. Phone Number: _____; Email: _____
2. Teacher/Day Care Provider _____
 - a. Phone Number: _____; Email: _____
3. Dentist/Orthodontist: _____
 - a. Phone Number: _____; Email: _____
4. Other: _____
 - a. Phone Number: _____; Email: _____

This release will remain in effect for the duration of services, unless revoked in writing. I understand that I may change this authorization at any time by notifying Speech EZ, LLC in writing.

Signature: _____ Date: _____

Printed Name: _____

Name of patient: _____

Relationship to patient: _____



HIPAA - Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protection of Health Information: Your health information is kept private according to the federal privacy regulations under the Health Insurance Portability and Accountability Act of 1966 (HIPAA) and you are provided with notices of the legal duties and privacy practices within this practice. Your protected health information is the information that relates to your past, present, or future health care. This includes your medication history, diagnostic evaluations, and therapeutic services.

Uses and Disclosures of Your Protected Health Information: Disclosure of your health information may occur for health care operations. Examples of operations in which protected health information disclosures may occur include insurance and billing, management, financial or quality assurance audits, law enforcement purposes, education, referring to other services, and receiving information from other professionals that may have treated you in the past. Your protected health information may be used for treatment purposes including provisions, coordination, or management of services. Some other examples of disclosures include the following:

- Messages may be left on your answering machine regarding your appointment or to request that you contact this office
- Medical records may need to be transferred to another location
- Disclosures may also be made to student observers or therapists who participate in health care operations and commit to respecting the privacy of your health information

Your Rights Regarding Your Health Information: You have the right to review your health information which might include intake information, evaluation, goals, and progress notes. For all other purposes beyond those listed above, your written authorization will be required to use, disclose, or restrict your protected health information. Your authorization can be revoked at any time except to the extent that we have relied on the authorization. Revocations must be in writing. You may also initiate the process for your information to be sent to someone else through the use of an authorization form or written request. To request further restriction or disclosure, you must submit a written request that explains what information you want restricted, how you want the information restricted, and from whom you want the restriction to apply.

Notice of Privacy Practices: By law, this practice abides by the terms of this Notice of Privacy



Practices until we choose to change it. We reserve the right to change this notice at any time. The revised notice will be available on request from our office.

Complaints: If you believe that your privacy rights have been violated, you may submit a complaint to this practice or to the U. S. Department of Health and Human Services. To file a complaint with the practice, submit the complaint in writing. You will not be penalized or retaliated against for filing a complaint and your identity will be kept confidential.

Signature: _____ Date: _____

Printed Name: _____

Name of patient: _____

Relationship to patient: _____