ACT Speech Therapy

Patient Consent

I hereby authorize ACT Speech Therapy, PLLC to directly receive payment of pertinent insurance benefits; to release information including protracted health information (PHI) 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, 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. I understand that my account will be charged $25.00 for any checks returned due to non-sufficient funds. I agree to promptly alert ACT Speech Therapy, PLLC should there be any changes related to insurance and other information I provided above.

With my consent, Rebecca Rowe, owner of ACT Speech Therapy, PLLC may e-mail (_____) and/or call/contact my home or other designated location (cell _____ and/or work _____) and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out, such as appointment reminders, insurance items, billing items, and any call pertaining to clinical care including test results.

With my consent, ACT Speech Therapy, PLLC may mail to my home or other designated location any items that assist them in carrying out treatment, payment, or health care operations (TPO) such as appointment reminder cards, patient statements, and test results as long as they are marked Personal and Confidential.

Name and Signature of Responsible Party: ***Date:***

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Reviewed by:

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Date:

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