

Communication Matters

Speech-Language Pathology

A Professional Corporation

"Enhancing Lives Through Communication"



Patient Name: _____ Age: _____ Birth date: _____ M ___ F ___

Name of Parents/Spouse/Guardian: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Patient's Cell Phone: _____

Mom Cell: _____ Dad Cell: _____ Email address: _____

Patient's Physician: _____ Physician Phone: _____

Payment Plan selected:

Time of service Monthly Prepay Monthly Auto Prepay Monthly Statement Other: _____

Cancellation and No-Show Policies:

Communication Matters requires 24 hours notice of need for cancellation to be eligible for a make-up session. Make-up sessions must occur within 2 weeks of the cancelled session and are subject to availability. A make-up session with a substitute clinician may be necessary due to scheduling constraints. No-shows will incur an automatic charge of \$40 and are not eligible for make-ups. Consistent attendance is required to receive benefit from speech-language pathology intervention. If attendance is 75% or less over 2 months, a meeting with the patient (and family), clinician, and director will be scheduled to review goals and program commitment. We reserve the right to change standing appointments, to place services on hold, or to discontinue services. _____ **initial**

Safety Policies:

Communication Matters requires that all children under the age of 13 be accompanied in and out of the office by an adult, parent, or guardian. Children may not be left unattended in the waiting area. There is no supervision available. Patients must be accompanied by a Communication Matters staff member to enter any treatment rooms, materials room, kitchen, or gym. The business office is for staff only. _____ **initial**

Consent and Privacy:

I **consent** / **do not consent** to video/audio taping or photography for treatment purposes.

I have received a copy of the Health Information Portability and Privacy Act (HIPPA) policy. _____ **initial**

I have read and agree to abide by the above policies. I understand that I may request a copy of this form at any time.

Signature of Responsible Party/Patient

Date