Consent for Treatment

I consent to the evaluation and/or treatment of (child's name) _____ by ABC Speech and Language Therapy, Inc.

Assignment of Benefits

If (child's name)_____ is entitled to benefits under the Medicaid/PeachCare, Amerigroup, PeachState, CareSource program, I authorize payment of benefits directly to ABC Speech and Language Therapy, Inc. I understand and agree that if child is receiving therapy as a private pay client, I am responsible for providing payment in full prior to each session. **I understand and agree that if I fail to disclose any changes in insurance, that results in a denial of payment. I am responsible for providing payment in full upon receipt of invoice from ABC Speech and Language Therapy, Inc.** I also understand and agree, that if I am covered under private insurance and a copay is required, the copay is to be paid prior to each therapy session.

_____

Parent/Guardian Signature **Date**

Consent to Release Information

I give ABC Speech and Language Therapy, Inc permission to release information to my referring physician, insurance company, head start, early intervention, child care provider or to any other person or parties financially responsible for my treatment for the purposes related to a claim for payment and/or approval of services. This permission will also give ABC Speech and Language Therapy, Inc. the right to discuss my child's treatment plan with others that come in contact with my child on a daily basis to promote carryover of goals in their natural environment.

_____

Parent/Guardian Signature **Date**

Privacy Statement

We respect your right to privacy. Any information that you give to ABC Speech and Language Therapy, Inc. will be held in the strictest of confidence and will not be utilized in ways to which you have not given permission to disburse.