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Privacy and Confidentiality

All information received, and therapies performed are considered private and confidential. This information may not be discussed or released, by any individual within this office without your written consent. A release giving permission to share information regarding your services will be provided, in the event information needs to be shared with another professional (i.e. pediatrician, teacher, and other therapists).

As these roles and expectations have been defined, your child's success will be influenced by consistency. The parents carry over of strategies used in the therapy session to the home will be vital to the rate of progress seen in your child. The consistency in attendance to therapy will also greatly influence your child's progress. With all the members of your child's "team" working together toward the same goal, we will maximize your child's progress and confidence.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

Consent to Treat a Minor

As parent or legal guardian of ________________________ I authorize his/her evaluation and treatment. I have the right to request information concerning the above minor's evaluation and treatment.

Parent/Legal Guardian Name: ___________________________

Parent/Legal Guardian Signature: ________________________ Date: __________

Consent to participate in treatment in a natural environment

__________________________ has my permission to participate in therapy/activities/sessions in natural environment settings during speech therapy sessions. I understand that this includes the presence of a wide variety of people including other children, siblings, parents, co-workers, volunteers, students, and other community members. In addition to the natural play environments on location; my child may participate in therapy in the home, school, and community to maximize carryover of functional skills.

Parent/Legal Guardian Signature: _________________________Date: _________