



**AMPLIFY**  
SPEECH THERAPY • FIND YOUR VOICE

## CONSENT TO EVALUATE AND/OR PROVIDE TREATMENT

I authorize Amplify Speech Therapy, LLC to render appropriate therapy services to \_\_\_\_\_ . I understand that care will be provided by an appropriately trained and licensed health care professional. I recognize and agree that I have the right to refuse treatment or terminate services at any time. In addition, Amplify Speech Therapy, LLC may terminate services by notifying me of termination. I hereby authorize Amplify Speech Therapy, LLC to bill any applicable insurer identified by me and allow for the release of information necessary to process claims for medical benefits.

Amplify Speech Therapy uses HIPAA compliant communication and virtual therapy platforms but cannot eliminate all risks inherent in using videoconferencing. These limitations may result in technical failures, or unauthorized access to therapy sessions or medical information. It is also the client's responsibility to secure one's own computer and internet access for successful therapy sessions. It is advised to establish an environment and location with sufficient lighting and privacy and free from distractions and interruptions for optimal success for each teletherapy session.

I consent to telehealth services for speech therapy during the current health emergency. In accordance with the Centers for Medicare and Medicaid Services (CMS) requirements, I will be notified in writing if/when telehealth services are no longer a covered and approved benefit by CMS.

### Client/Authorized Representative Signature

I have read and fully understand the content of this consent and authorization release, and hereby agree to and authorize the foregoing provisions. As used in this document, the terms "I" "me" and "my" refer to and include, in addition to the undersigned, the client named above and other for whom the undersigned is responsible, or for whom the undersigned has assumed responsibility engaging in Amplify Speech Therapy, LLC to provide services to the client. This consent and authorization is valid until revoked by me in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

If other, Relationship to Patient: \_\_\_\_\_