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. 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.

I have read Amplify Speech Therapy's privacy notice of how my personal health information may be shared according to HIPAA (medical release form) and how I may obtain further information about my rights.

Client/Authorized Representative Signature

I have read and fully understand the content of this consent and medical release authorization, 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 are valid until revoked by me in writing.

Signature: _____ Date: _____

Printed Name: _____

If other, Relationship to Patient: _____