LAKESHORE
SPEECH THERAPY, LLC.

CONSENT FOR THERAPY SERVICES

I, _____, hereby agree to the following:

CONSENT TO CARE:

I am presenting myself for diagnosis and treatment, and I voluntarily consent to the providing of such care including diagnostic procedures and medical treatment by employees and agents of this practice and by its staff as may in their judgment be necessary or advisable to treat my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the results of treatments in this practice.

PRIVACY NOTICE AND USE OF PROTECTED HEALTH INFORMATION (NPI):

I acknowledge that I have received the Notice of Privacy Practices of Lakeshore Speech Therapy, LLC as described in the Policies and Procedures. I understand that the Notice of Privacy Practices explains how Lakeshore Speech Therapy, LLC may use and disclose confidential health information that identifies me. I consent to let Lakeshore Speech Therapy, LLC use and disclose health information about me as described in the Notice of Privacy Practices. This includes information about substance abuse, mental health services and HIV if applicable. I consent to the release of health information to my insurer, other third party payors, and any agents or consultants that assist in my treatment, help Lakeshore Speech Therapy, LLC obtain payment for services or carry out its operations.

You have the right to read our notice before signing this Consent. The terms of the Notice may change from time to time. If we change our notice, you may obtain a revised copy from our therapy staff.

GUARANTEE OF ACCOUNT:

In consideration of facility services to be rendered, I guarantee payment to this facility for all

charges incurred on behalf of the client receiving therapy services, including any portion not paid by any insurance organization, Medicare or Medicaid. Many insurance carriers require patients to call and receive prior authorization and/or notification for a procedure/treatment to be covered. Failure to comply may result in the patient or guarantor being responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS:

In consideration of therapy services to be rendered, I assign, transfer and convey all of the rights, titles and interest due me from any insurance organization, Medicare or Medicaid in payment on my behalf to Lakeshore Speech Therapy, LLC.

I authorize the Social Security Administration to release to Lakeshore Speech Therapy, LLC information regarding my Medicare entitlement.

This authorization will remain in effect for all care provided by this facility until expressly revoked in writing by me.

I acknowledge that the treatment for which I give this consent has been fully explained to me and I have read and fully understand this authorization as it applies to me.

My signature acknowledges that I have received the Policies and Procedures of Lakeshore Speech Therapy, LLC; I have reviewed the information, and acknowledge and agree to said policies and procedures.

Date: _____ Time:_____ _____

(Client, Guardian, Administrator, Next of Kin)

_____ _____

Witness

Insured Certificate Holder
(If different from above)