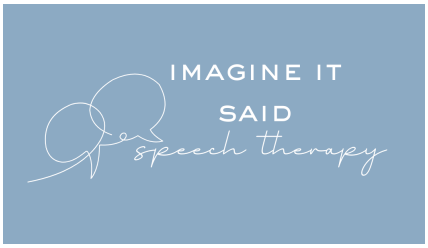


Consent to Speech Therapy Services

I hereby consent and authorize Imagine It Said Speech Therapy to evaluate, diagnose, and provide speech treatment for _____.

Financial Policy

Thank you for choosing Imagine It Said! Please note that Imagine It Said Speech Therapy is a private pay practice at this time and does not accept insurance.

Prior to scheduling an evaluation or first treatment session, a credit card must be placed on file. A 50% deposit will be required to schedule an evaluation. Deposit is placed towards evaluation cost and balance is due at time of service. If the evaluation appointment is not canceled within 2 days, client forfeits their deposit.

All payment for services is required at the time services are rendered. We accept payment by cash, credit card (Visa, MasterCard, American Express, Discover) or HSA.

Acknowledgment

I, _____, acknowledge and accept complete responsibility for payment of all services rendered by Imagine It Said Speech Therapy and/or its consultants. I understand that I am responsible for prompt payment of any cancellation or no-show fees incurred as outlined in the Attendance and Cancellation Policy. I have read, understand, and hereby agree to the Financial Policy of Imagine It Said Speech Therapy.

Signature: _____ Date: _____

Printed Name: _____

Name of patient: _____

Relationship to patient: _____

Attendance and Cancellation Policy

In order to better serve you and make quicker progress toward goals, regular attendance to therapy is imperative. The most common cause of lack of progress is inconsistent attendance. Please thoroughly read and initial next to your responsibilities outlined as follows:

_____ I am responsible for attending speech/language/voice therapy sessions as scheduled. I understand that I must maintain at least an 80% attendance rate as measured within a given 3-month period or risk losing my appointment slot.

_____ In the event of a cancellation, I will provide as much notice as possible. “Non-emergency” cancellations require at least 24 hours’ notice and include vacations, pre-planned medical appointments, family events, parties, sports events, lack of babysitters, or anything that is not designated as an “emergency”. If the session is not canceled within 24-hour notice I understand I will be responsible for paying the full cost of my session. “Emergency” cancellations are accepted only for illness (fever within the last 24 hours, strep, unidentified rash, diarrhea, vomiting, or any highly contagious illness), illness of a family member, or death in the family. After 3 emergency cancellations, I understand that a $30 charge will be incurred for all subsequent emergency cancellations within a calendar year. In the event of an emergency cancellation, I understand I still must notify the clinic on the day of the appointment to avoid a “no-show” fee for the full cost of my session rate.

_____ I understand that Imagine It Said Speech Therapy may send me an email reminder the day before my scheduled appointment, as a courtesy. I recognize that my attendance is not dependent upon the receipt of an email reminder.

The email below is my preferred email for receiving courtesy appointment reminders:

Email: _____

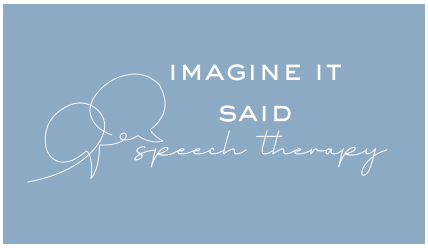
I have read, understand and agree to Imagine It Said Speech Therapy Attendance and Cancellation Policy as outlined above.

Signature: _____ Date: _____

Printed Name: _____

Name of patient: _____

Relationship to patient: _____



Release Form

Melissa often records sessions for progress monitoring and session planning. There are instances where Melissa shares short videos of effective therapy techniques from her sessions on her social media platforms that SLPs and parents alike find helpful. These videos are most frequently of herself only, though audio may include the child's voice in the background. Though not required, please consider allowing these helpful video shares to continue by signing the agreement below and selecting the degree of exposure with which you're comfortable.

I give permission to Imagine It Said Speech Therapy to take and use (check all that apply):

- ▫ Audio recordings
  - ▫ For progress monitoring and planning
  - ▫ On social media, including Instagram and/or Facebook
- ▫ Video recordings
  - ▫ For progress monitoring and planning
  - ▫ On social media, including Instagram and/or Facebook
- ▫ Photographic images
  - ▫ For progress monitoring and planning
  - ▫ On social media, including Instagram and/or Facebook

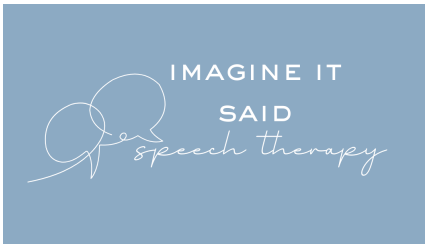
▫ I do NOT give permission for any of the above.

Signature: _____ Date: _____

Printed Name: _____

Name of patient: _____

Relationship to patient: _____



HIPAA- NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protection of Health Information: Your health information is kept private according to the federal privacy regulations under the Health Insurance Portability and Accountability Act of 1966 (HIPAA) and you are provided with notices of the legal duties and privacy practices within this practice. Your protected health information that relates to your past, present, or future health care. This includes your medication history, diagnostic evaluations, and therapeutic services.

Uses and Disclosures of Your Protected Health Information: Disclosure of your health information may occur for health care operations. Examples of operations in which protected health information disclosures may occur include insurance and billing, management, financial or quality assurance audits, law enforcement purposes, education, referring to other services, and receiving information from other professionals that may have treated you in the past. Your protected health information may be used for treatment purposes inducing provisions, coordination, or management of services. Some other examples of disclosures include the following:

- Being called in from the waiting room when it is time for your appointment
- Messages may be left on your answering machine regarding your appointment or requesting that you contact this office
- Medical records may need to be transferred to another location
- Disclosures may also be made to student observers or therapists who participate in health care operations and commit to respect the privacy of your health information

Your Rights Regarding Your Health Information: You have the right to review your health information which might include intake information, evaluation, session notes, goals, and progress notes. For all other purposes beyond those listed above, your written authorization will be required to use, disclose, or restrict your protected health information. Your authorization can be revoked at any time except to the extent that we have relied on the authorization. Revocations must be in writing. You may also initiate the process for your information to be sent to someone else through the use of an authorization form or written request. To request further restriction or disclosure, you must submit a written request that explains what information you want to be restricted, how you want the information restricted, and from whom you want the restriction to apply.

Notice of Privacy Practices: By law, this practice abides by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time. The revised notice will be available on request from our office

Complaints: If you believe your privacy rights have been violated, you may submit a complaint to this practice or the U. S. Department of Health and Human Services. To file a complaint with the practice, submit the complaint in writing. You will not be penalized or retaliated against for filing a complaint and your identity will be kept confidential.

Acknowledgment That You Have Received Our HIPAA Notice of Privacy Practices

Imagine It Said Speech Therapy is required by law to keep your health information safe.
This information may include:

- notes from your doctor, teacher, or other health care provider
- your medical history
- your test results
- treatment notes
- insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared. It also tells you how you can look at and comment on your information.

By signing this page, you are saying that you have reviewed and been offered a copy of our privacy notice.

_____ _____

Print Patient's Name Date

_____ _____

Parent/Guardian Signature Relationship to Patient