Speech and Feeding of Frisco, LLC
Comprehensive and Compassionate Therapy

DATE: _____

PATIENT DEMOGRAPHICS

PATIENT INFORMATION

Patient Name: _____
Last *First* *Middle*

Sex: M / F Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

How did you hear about us?: _____

RESPONSIBLE PARTY

PARENT/GUARDIAN

Name: _____ Sex: M / F
Last *First* *MI*

Relationship to Patient: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

OTHER PARENT/GUARDIAN

Name: _____ Sex: M / F
Last *First* *MI*

Relationship to Patient: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

INSURANCE INFORMATION

Insurance Company: _____ Subscriber Name: _____

Subscriber DOB: _____

Subscriber ID: _____ Group #: _____

Speech and Feeding of Frisco, LLC
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Patient Name: _____
DOB: _____

Patient Consent and Service Agreement

1. Consent to Treatment:
   - I authorize Speech and Feeding of Frisco (SFF) and its employees to provide speech therapy evaluations and treatment to me or my child.
   - No guarantees have been made to me about the outcome of therapy.
   - This consent will remain in place until patient is discharged from treatment.
2. Arrival Policy:
   - Please arrive 5 minutes prior to your scheduled session.
   - If you are late, your session will conclude at its usual time.
   - Parents/Caregivers must be in the clinic 5 minutes prior to the end of the session.
3. Attendance Policy:
   - If you are not able to attend a scheduled therapy session for any reason, and choose to not reschedule, there will be a cancellation fee of $25.00 per session (the fee will be waived if the session is rescheduled within the same week).
   - Visits canceled with more than 1 weeks notice will not be subject to a cancellation fee.
   - Frequent cancelled or missed sessions may result in the loss of your reserved weekly therapy time slot.
4. Financial Policy: (See Financial Policy for further details)
   - Payment for all sessions are due at the time services are rendered.
   - A patient with a balance on their account of greater than $70.00, for more than 30 days, may be discharged.
5. Discontinuation Policy:
   - When termination of therapy services is voluntary, SFF requires one weeks' notice.
   - If one weeks' notice is not given, cancellation fees will be applied.
6. I have been informed that my child may be seen by others during therapy sessions at SFF. This is due to the fact that families are coming and going before and after each session.
7. SFF is a teaching facility and at times has volunteers and speech therapy students here to observe and learn. I authorize SFF to have students and/or volunteers observe treatment. I further authorize supervised students to work with me or my child.
8. SFF will occasionally videotape or audiotape patients for the use of evaluation or treatment. These videos and/or audiotapes are solely used by the therapist and will remain confidential. Videos and/or audiotapes will not be released for any other purpose without prior knowledge or specific consent.

_____ _____

Patient or Parent/Guardian Signature **Date**

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Financial Policy

Evaluations

Speech and Feeding of Frisco (SFF) offers evaluations and therapy sessions for the following services:

- Parent/Caregiver Education
- Receptive and Expressive Language Therapy
- Articulation/Speech Therapy
- Phonological Processing Therapy
- Cognitive Therapy
- Augmentative Communication Therapy
- Voice Therapy
- Fluency Therapy
- Oral Motor Therapy
- Feeding and Swallowing Therapy

Evaluations may take up to 2 hours to complete and may include, but are not limited to, the following:

- Patient case history
- Standardized speech and language assessments
- Feeding assessment
- Voice assessment
- Fluency assessment
- Parent education

Evaluations are ***$200.00*** per assessment.

Therapy Sessions

Therapy sessions will follow the individualized plan of care created after the patient's evaluation. These sessions will be 30 or 60 minutes in length. A 30-minute session is ***$75.00*** and a 60-minute session is ***$120.00***. The length of the session is determined by the patient's tolerance level and scheduling capabilities of the family and clinician.

Insurance

Patients will be financially responsible for all visits. SFF is out-of-network with all insurance plans and provides each family with 2 options:

1. SFF will collect the full price of the visit upfront and provide each patient with the necessary documentation, including billing codes, required to submit an insurance claim.
2. SFF will collect the copay/coinsurance for the visit upfront and file with the insurance company for a $3 fee per visit. This fee is not reimbursable through insurance.

Attendance

If a patient is late or needs to leave early, the patient will be charged for the entire length of their scheduled session. If the clinician must shorten the session, the session will be prorated accordingly.

Patients must give 1 week's notice to cancel their visit without a cancellation fee. Visits canceled with less than 1 week's notice, and not being rescheduled, will be subject to a ***$25.00*** cancellation fee. Visits able to be rescheduled within the same week will not be subject to a cancellation fee.

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If a patient does not call and does not show up to their scheduled session, patient will be charged the full rate of their scheduled session.

Payment

Payment for all sessions are due at the time services are rendered. Payment may be made with cash, check, or charge. A 2% convenience fee will apply to all credit card charges. A patient with a balance on their account of greater than $70.00, for more than 30 days, may be discharged.

By signing below, I acknowledge that I have reviewed this document and will comply with the financial policy as written.

_____ _____
Parent/Caregiver Signature Date

_____ _____
Clinician's Signature Date

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DOB: _____

Consent to Release Private Information

I hereby authorize **Speech and Feeding of Frisco** to use or disclose health information about my child. The use or disclosure shall be limited to the information, persons, purposes, and timeframe described below.

Information to be used or disclosed

I authorize the use or disclosure of the following protected health information:

- ☐ Evaluations
- ☐ Therapy Visits
- ☐ Communication Documentation
- ☐ Patient Care Summaries (including Discharge Summaries)
- ☐ Other: _____

Speech Language Pathology Records

I hereby authorize **Speech and Feeding of Frisco** to release the above information to and obtain information from:

☐	_____ Child's School	_____ Phone Number	_____ Fax Number	_____ Email Address
☐	_____ Caregiver Name	_____ Phone Number	_____ Fax Number	_____ Email Address
☐	_____ Physician	_____ Phone Number	_____ Fax Number	_____ Email Address
☐	_____ Other	_____ Phone Number	_____ Fax Number	_____ Email Address

I understand that I may change this authorization at any time.

_____ _____
Parent/Guardian Signature Date