818 E. Fifth St. South Boston, MA 02127 (857) 257-9081
www.bostonspeec.com

Informed Consent for Evaluation and/or Treatment

I, _____, parent/guardian of _____

consent to the evaluation and/or treatment by Boston Speech Therapy. I acknowledge by signing below that I have been informed and understand all the information provided with regard to the evaluation and/or treatment of my child by Boston Speech Therapy. I have obtained a prescription from my doctor authorizing Occupational and/or Speech Language Evaluation and/or Treatment.

Assignment of Benefits

I hereby assign and convey directly to Boston Speech Therapy, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments and/or therapies rendered by Boston Speech Therapy. I hereby authorize Boston Speech Therapy to release all medical information necessary to process claims on my behalf. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Payment Responsibility

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and **I am responsible for any co-payments and/or deductibles**.

Release of Information

I authorize the release of any medical information to any educator, doctor, insurance carrier or caregiver, to determine and process benefits payable for services rendered unless otherwise noted at the bottom of this form.

Therapists

I understand that Boston Speech Therapy has a variety of professionals working. At times, clients are seen by Speech Language Pathologists (SLP), Speech Language Pathology Assistants (SLPA), and or Clinical Fellowship Year Interns (CFY)

Print Full Name: _____ Date: _____

Parent/Guardian Signature:_____ Child's Name: _____