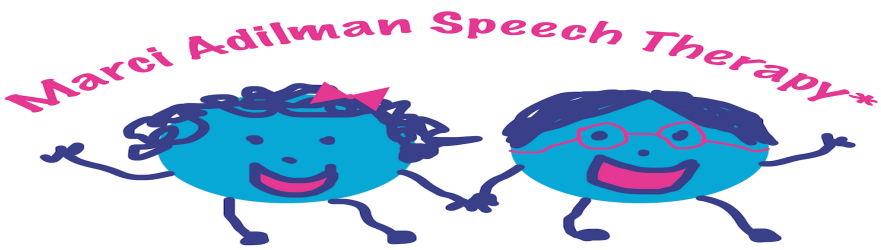

POLICIES AND PROCEDURES ACKNOWLEDGEMENT FORM

Name of Child: _____Date of Birth: _____

I, _____, herby consent to the evaluation, treatment, and billing for my child. The assessment may include: parent interviews, observation of the child, formal and informal testing, follow up visits, and ongoing intervention. I understand that the results of the Assessment and the Plan of Care will be shared with me. I agree to comply with the Plan of Care to the best of my ability for the best outcome for my child. I understand that at any given time I have the right to refuse care and revoke my consent for treatment with Marci Adilman Speech Therapy, LLC.

I consent to and assume all risks and hazards of and incidental to the participation of the above named child in the activities of Marci Adilman Speech Therapy, LLC, and I agree to indemnify and hold harmless the said organization and its officers, employees, or agents nominated or appointed by or on its behalf against all loss from any claim hereafter made against it, them or any of them by or on behalf of said child and arising directly or indirectly from such participation.

Marci Adilman Speech Therapy, LLC deem it its responsibility to provide effective and quality treatments to its clients in a safe environment. If a therapist feels that a situation is unsafe for them personally, Marci Adilman Speech Therapy, LLC, reserves the right to discontinue services.

Marci Adilman Speech Therapy, LLC has an obligation and responsibility to its professional guidelines and standards of practice; therefore, when a child no longer qualifies for services or therapy is no longer effective or productive for various reasons, a discharge summary will be completed.

Please initial each section to acknowledge acceptance of policies and procedures.

SESSION PARTICIPATION AND CANCELLATION POLICY:

_____I agree to actively participate in the scheduling of my child's sessions and understand that 3 unscheduled absences may result in discharge from therapy services until scheduling conflicts are resolved. In addition, I agree to be available to assist my child's therapist regarding sessions, in the compliance with the plan of care, and following the home program under the direction of my child's therapist.

_____ We require 24 hours notice for cancellations. Cancellations made prior to this window are rescheduled with no penalty. No-shows or cancellations made without 24 hours notice incur the full fee. This also includes Medicaid recipients, and the fee will not be covered by Medicaid. We understand that sometimes a child is ill and unable to attend the session. If this is the case, please

call as soon as possible, but not later than the evening before the session is to take place. Charging a cancellation fee when a client is ill and cancels late will be at the clinician's discrepancy.

_____Please do not attend a session with a child that is ill. We treat many medically fragile children and must minimize risk to clients and clinicians.

PAYMENT POLICY CONSENT:

_____ Payment is due at time of service, and online storage of credit card information for automatic, recurring processing is the preferred payment method. We accept debit/credit cards (Visa, Mastercard, Discover and American Express). We also accept cash/check due at the time of service. There will be a 35$ charge for a returned check.

_____I authorize my Medicaid benefits be paid directly to Marci Adilman Speech Therapy, LLC if applicable.

_____I agree to place a credit card on file to be processed for sessions not paid by cash/check as well as any cancellation fees that may occur. Credit cards for treatment sessions and evaluations will be charged by the end of the work day on the day that the service occurred.

RELEASE OF INFORMATION CONSENT:

_____I authorize, Marci Adilman Speech Therapy, LLC, to release information to health professionals or Medicaid in order to process all medical claims on the patient's behalf through written or verbal communication, via regular mail, electronically or by fax.

Patient Name _____

Parent/Caregiver Name _____

Parent/Caregiver Signature _____

Date _____