SPEECH PATHways
Pathways to Communication Enhancement

www.speechpathways.net

SPEECH PATHways Client Registration

Date: _____

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____ Responsible Party: _____

Address:

_____

_____

Home Phone: _____ Work Phone: _____

Cell Phone #1:_____ Cell Phone #2_____

E-mail Address:_____

Employer/Address:_____

_____

Primary Care
Physician/Address/Phone:_____

_____

Diagnosis (Reason for Treatment): _____ Onset Date: _____

I certify that the above information is true. I will notify SPEECH PATHways of any changes to the above information.

_____ _____

Print Patient's Name **Patient Signature or Responsible Party**

Thank you for choosing SPEECH PATHways for your speech-language pathology services.

SPEECH PATHways Clinic
Shoppes at Meadow Creek
410 Meadow Creek Drive, Suite 206
Westminster, MD 21158

SPEECH PATHways Consent for Treatment

This agreement will serve as notification that payment for all therapy services is due and payable at the time of service or in advance through our monthly credit card billing option. You will receive a monthly itemized "superbill" statement for your records. It will be your responsibility to submit and pursue insurance reimbursement if these services are covered. SPEECH PATHways is not accepting or billing your insurance carrier. Payment can be made via cash, check or credit card.

In the event that you need to cancel or reschedule 24 hour notice is appreciated. Please see the SPEECH PATHways cancellation policy for complete details on charges that may apply in the event that 24 hour notice is not provided.

If you wish reports to be submitted to your physician, you must complete the information below:

Doctor's name: _____

Address: _____

Phone #: _____

Fax #: _____

If all terms above are agreeable and acceptable please sign below. By signing you are hereby consenting to treatment.

_____ _____

Patient's Name **Responsible Party (if minor)**

August 18, 2014

Dear Client:

Effective September 1, 2014 SPEECH PATHways will be the changing attendance/cancellation policy. Please read the following notice carefully and discuss any questions with your therapist and/or Kimberly Bell (owner). The fee for less than 24-hour cancellation notice and/or no-show appointments will remain at $60.00 for 50-minute (clinical hour) sessions and will be $40.00 for 25-minute (clinical half-hour) sessions. SPEECH PATHways will be willing to make exceptions to this policy only in rare, extenuating circumstances. Please keep in mind that careful planning and preparation goes into your child's therapy sessions. When a session is missed, it leaves an open therapy spot for another child/client who would benefit from SPEECH PATHways services. In addition, consistency is crucial in the remediation of speech and language deficits.

New to this policy is the ATTENDANCE REQUIREMENT. All clients will be required to maintain the industry standard of at least a minimum of 80% attendance overall. In the event that attendance becomes a chronic issue and you fall below the 80% attendance rate, you will be notified in writing that your time slot is in jeopardy. You will be required to pay for the entire session fee if you wish to maintain your current treatment time. This policy will only be instituted as a result of a high frequency of last minute cancelations and/or no-show appointments.

Please complete the next page of this letter and return to SPEECH PATHways. Your therapist can provide you with a copy of this signed document for your records. If you have any questions regarding this matter, we would be happy to discuss it with you.

I _____, understand that there will be a $60.00 fee for the clinical hour (50-minute session) and a $40.00 fee for the clinical half hour (25-minute session) when less than 24-hour cancellation notice is given and/or no-show appointments occur. In addition, if my attendance rate drops below 80% overall I understand that my time slot is in jeopardy and I may be forced to change times or pay the entire session fee ($65/$90) to maintain the current time slot). I fully understand that consistent attendance is important to the improvement of the client's speech and language progress and failing to follow a consistent attendance policy will likely negatively impact progress and development. The fee for missed appointments must be collected prior to (or at) your next scheduled appointment.

_____
Patient Name

_____
Date

_____
Patient or Guardian Signature

_____
Therapist Signature

Check Return Policy

There will be a $25.00 charge for all returned checks for non-sufficient funds. The sum of the original check plus the $25.00 NSF charge must be received prior to any further visits.

By signing you are agreeing to the above terms.

_____ _____

Patient's Name **Signature of Responsible Party**

Dear Clients,

SPEECH PATHways does not automatically follow the Carroll County School Inclement Weather Policy for closings and delays. Please check directly with your therapist to see if SPEECH PATHways is open on a particular day by contacting the Westminster Clinic at 410-386-0199.

We have found that many times the roads have been cleared by the time we begin services in the evening. If your appointment time is in the morning (prior to noon) and the Carroll County Schools are closed then your appointment will be cancelled or rescheduled. .We will make every attempt to see your child when deemed safe and appropriate in relation to the weather conditions.

Sincerely,

Kim

Kimberly A. Bell, M.S.,CCC-SLP
Owner/Speech-Language Pathologist