GRAY
Consulting & Therapy, LLC

Consent for Treatment, Payment and Photography Release

Client Name: _____ DOB: _____

Consent for Treatment

By signing below, I hereby give permission to Gray Consulting and Therapy, LLC to provide evaluation, consultation, or therapy services to (client name)_____.
It is understood that the provider will consider any personal identifying information as privileged and will hold such information in confidence.

Payment Policy: Insurance and Self Pay

Please read the following information carefully.

Gray Consulting & Therapy, LLC does not bill insurance companies for evaluations and treatment, and therefore are "out of network" for insurance policies. We will provide you with the information you need to submit a bill to your insurance company, when requested, however you are responsible for payment.

If you plan to submit bills to your insurance company, you should:

- Check with your insurance company before your first visit to find out what speech and language services are covered.
- Find out what information the insurance company needs.
    - You may need a note from your doctor, called a referral. You may need permission from the insurance company, called pre-authorization.
    - Referrals and pre-authorizations do not guarantee that insurance will pay for services.

Payment Options:

1. Payment for therapy is due at the time of service. We accept cash, checks and credit card payments.
2. Short-term financing options are available through CareCredit
3. You will be billed for services at the end of each month. Payment is due within 30 days of receiving our bill.

Rate: Services billed at agreed upon our current rates, which are updated annually. We will provide the current rates prior to starting services.

Returned checks:

- You will be charged a $30 fee for each returned check.
- You will be asked to bring cash to the office to cover the amount of the returned check and the fee.

Past due accounts:

- You are expected to pay in full within 30 days of receiving our bill.
- Accounts 3 months past due will be sent to a collection agency. You will be responsible for collection costs, as well as attorney fees and court costs.

I agree to payment policies as outlined above.
Initial: _____ Date: _____

Photography Release

I understand that as part of therapy, the client may be photographed, audio-taped, or videotaped. Examples of this include video modeling social skills, audio taping voice or articulation, or taking photographs of a wheelchair/positioning equipment. This information could also be used for professional development and training purposes. Please know that you have the right to decline or restrict whether or not we collect this information. Please check YES or NO to indicate your permission and any restrictions on photographs, audio, or video information:

YES	NO	
		I give permission for Gray Consulting and Therapy to obtain photographs, audio recording or video recording ***as part of the evaluation or treatment.***
		I give permission for Gray Consulting and Therapy to use photographs, audio recording or video recording ***for professional development or training purposes***. I understand the client's name will not be used.
		I give permission for Gray Consulting and Therapy to obtain photographs, audio recording or video recordings, ***with the following restrictions*** on how it can be used:

		_____ _____
		I ***DO NOT*** give permission for Gray Consulting and Therapy to obtain photographs, audio recording or video recording as part of their evaluation or treatment.

Email List

By providing my email address below, I give permission to Gray Consulting and Therapy, LLC to provide me with notices, newsletters and general updates about the practice. Gray Consulting and Therapy, LLC will not sell, release, or pass on your email address or other personal information to any third party organization. I understand I can opt out of these notifications at any time by contacting Gray Consulting and Therapy. If left blank, you will not receive email updates.

Email address:_____

I understand that I may revoke this authorization at any time by submitting a written statement of revocation to Gray Consulting and Therapy, LLC.

_____ _____

Signature (or parent/legal guardian) Date

_____

Printed name if parent/guardian/relationship to client