CLERMONT SPEECH AND LANGUAGE THERAPY CENTER, LLC

Patient Name:_____

DOB:_____

MEDICAID AND INSURANCE CONSENT FORM

I, _____, hereby authorize this Center (Clermont Speech and Language Therapy Center, LLC) to apply for benefits on my behalf for covered services rendered. I hereby authorize payment of all medical insurance benefits, which are payable to me under the terms of my insurance policy, to be paid directly to this Center for services rendered. I further authorize the release of any information needed for processing my insurance. I certify that the information I have reported with regard to my insurance is correct. I understand that I am responsible for co-insurance and services not covered by my insurance company

_____ _____
Patient/Parent/Guardian Signature Date

PATIENT PRIVACY

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPAA"), I have certain rights to privacy regarding my protected health information.
BY SIGNING BELOW I ACKNOWLEDGE BEING NOTIFIED OF THE PRIVACY PRACTICES OF CLERMONT SPEECH AND LANGUAGE THERAPY CENTER. LLC
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Patient Name: _____
Signature: _____
Date: _____

If patient is unable to consent on his/her own behalf, then a parent/guardian must sign below:
Signature of Parent/Guardian: _____
Relationship to Patient:_____
Date: _____
Signature of Witness _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:
Date:
Initials:
Reason:

CLERMONT SPEECH AND LANGUAGE THERAPY CENTER, LLC