

Athens:
1005 W Market Street, Ste 4
Athens, AL 35611
Phone: 256-431-4223
Fax: 256-472-4300



Muscle Shoals:
2836 E 2nd St
Muscle Shoals, AL 35661
Phone: 256-262-8500
Fax: 256-262-8510

Patient Name: _____ Date of Birth: _____

Acknowledgement of Our HIPAA Privacy Notice

HIPAA: Health Insurance Portability and Accountability Act. This means that Pathways Speech Therapy, Inc. is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to provide you with our privacy notice. This notice tells you how your health information may be used and shared.

- ☐ **I acknowledge** that I have received a copy of Pathways Speech Therapy Inc HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.
- ☐ **I have had** the opportunity to read the privacy notice and have had any questions regarding the notice answered to my satisfaction.
- ☐ **I understand** Pathways Speech Therapy Inc. cannot disclose my health information other than as specified in the notice.
- ☐ **I understand** that Pathways Speech Therapy Inc. reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

Print Patient Name

Date

Signature of Patient or Legal Representative

Relationship to Patient

Please Note: It is your right to refuse to sign this Acknowledgement.
HIPAA Privacy Notice Acknowledgement

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above.
It could not be obtained for the following reason(s):

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: _____

Staff Member Signature

Date

{Continue to back}

Authorization to Release Information

I authorize Pathways Speech Therapy to release and discuss relevant information regarding my (or my child's) evaluation, treatment, scheduling, billing, and other necessary healthcare information with the individual(s) and/or office(s) listed below.

Authorized Individual/Office:

Relationship to Patient:

I understand that this authorization is voluntary and may be revoked at any time in writing, except to the extent that action has already been taken in reliance on this authorization.

Print Patient Name

Date

Signature of Patient or Legal Representative

Relationship to Patient

Acknowledgement & Assumption of Risk

☐ **I understand** that I am being asked to carefully read each of the provisions in this form. I acknowledge and agree to receive therapy services from Pathways Speech Therapy Inc. and/or any employee or independent contractor employed by Pathways Speech Therapy Inc.

☐ **I acknowledge** that there is some inherent risks associated with the use of therapy equipment that cannot be eliminated regardless of the care taken to avoid injuries.

☐ **I understand** the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding Pathways Speech Therapy Inc. and/or any employee or independent contractor employed by Pathways Speech Therapy Inc. accountable for any losses, injuries or other damages occurring to the patient and/or myself. I further understand that I am fully responsible for my own safety.

Print Patient Name

Date

Signature of Patient or Legal Representative

Relationship to Patient

Consent for Services

☐ **I authorize** Pathways Speech Therapy Inc. to render appropriate evaluation and therapy services to the patient named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time.

☐ **I do not** give my consent or am withdrawing my consent regarding Pathways Speech Therapy Inc. rendering evaluation and therapy services to the patient named below.

Print Patient Name

Date

Signature of Patient or Legal Representative

Relationship to Patient