PATHWAYS
SPEECH THERAPY INC.

102 Sanders Street
Athens, Alabama 35611
256.431.4223

Patient Name: _____ Date of Birth: _____

Acknowledgement That You Have Received Our HIPAA Privacy Notice

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 give you a copy of 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}

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 Name of Patient 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 Name of Patient Date

_____

Patient Date of Birth

_____ _____

Signature of Patient or Legal Representative Relationship to Patient