1. Informed Consent for Myofunctional Therapy

Patient Name: _____ DOB: _____

Responsible Party: _____ Relationship:_____

I understand that Orofacial Myofunctional Therapy (OMT) is a program of exercises and behavior modification techniques to improve function of the tongue, lips, face, and airway-related musculature.

I acknowledge that:

- OMT is non-invasive and based on neuromuscular re-education.
- The services provided by Key Myofunctional Therapy, LLC, Orofacial Myofunctional Therapist do not constitute **medical, dental, or speech-language pathology treatment, diagnosis, or care.**
- I have been informed of the nature and purpose of OMT and understand that results may vary.
- I understand that participation in this therapy is voluntary, and I may withdraw consent and discontinue participation at any time.
- I acknowledge that while every effort is made to improve function, no specific outcomes are guaranteed

I consent to participate in OMT with Key Myofunctional Therapy, LLC.

Signature: _____Date: _____

Parent/Guardian (if minor): _____Date: _____

2. Telehealth Consent Form

I consent to receive Orofacial Myofunctional Therapy via telehealth. I understand:

- The services may be delivered through electronic means including video, audio, and data communication technologies.
- Technology may have limitations and technical difficulties may occur.
- I must be in a private, secure space to protect confidentiality during each session.
- All reasonable efforts will be made to ensure the privacy and security of my health information, but telehealth may carry risks to confidentiality.
- I agree to participate from a location within a jurisdiction where Key Myofunctional Therapy, LLC is authorized to provide services.
- I may stop services at any time.

In case of an emergency, I will contact 911 or my local healthcare provider immediately.

Signature: _____ **Date:** _____

Parent/Guardian (if minor): _____ **Date:** _____

3. Financial Policy & Cancellation Terms

- Full program payment is due upfront at the time of booking.
- Packages are non-refundable after initiation.
- Key Myofunctional Therapy, LLC does not bill insurance. However, a superbill can be provided upon request **after four sessions of services have been completed.**
- Accepted payment methods include credit card, debit card, HSA/FSA card, or other forms agreed upon at the time of booking.
- A $50 fee may apply for appointments cancelled with less than 24 hours' notice.
- Missed appointments without notice (no-shows) may also incur the $50 fee.
- A $25 fee will be charged for returned or declined payments.

By signing below, I acknowledge that I have read, understood, and agree to the financial policies outlined above.

Signature: _____**Date:** _____

4. Photo/Video and Research Consent Form

Image Consent:

I consent Key Myofunctional Therapy, LLC to use photo and/or video documentation during treatment for clinical tracking purposes. These images will be used only in the patient record and not shared externally without additional consent unless I provide written permission.

☐ Yes ☐ No

Signature for Image Consent: _____ Date: _____

Research and Case Study Consent:

I grant permission for Key Myofunctional Therapy, LLC to use my de-identified case information and/or images for the following purposes:

- Scientific research or academic presentation
- Case study publication
- Professional and public education

All personal identifiers will be removed prior to use. I understand participation is voluntary, and I may revoke this consent in writing at any time without affecting my care.

☐ Yes ☐ No

Signature for Research Consent: _____ Date: _____

5. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Rights Under HIPAA

You have the right to:

- **Access your medical record** — You can ask to see or get a copy of your health record.
- **Correct your medical record** — If you believe something is incorrect or incomplete.
- **Request confidential communications** — You can ask us to contact you in a specific way (e.g., home vs. mobile).
- **Ask us to limit what we use or share** — You may request restrictions on use or disclosure.
- **Get a list of who we've shared your info with** — Known as an "accounting of disclosures."
- **Get a copy of this notice** — You can request this at any time.
- **Choose someone to act for you** — If you have given someone medical power of attorney, we'll work with them.
- **File a complaint** — You can complain if you feel your rights are violated.

Our Responsibilities

We are required by law to:

- Keep your protected health information (PHI) private and secure
- Notify you promptly if a breach occurs that may compromise your information
- Follow the duties and privacy practices described in this notice
- Obtain your written authorization for most non-routine uses or disclosures

How We May Use and Share Your Information

We may use and share your information:

- **For treatment** — To coordinate your care with other providers at your request
- **For payment** — To provide superbills if requested by you
- **For health care operations** — To evaluate and improve our services

- **With your written permission** — For family members, outside providers, or case studies
- **When required by law** — For public health, legal proceedings, law enforcement, etc.

We will never sell your information or use it for marketing without your written consent.

Your Choices

You can tell us your preferences for:

- Sharing information with family, friends, or caregivers involved in your care
- Including your information in professional case studies (de-identified)
- Contacting you by email, text, or phone for reminders or follow-up

To File a Complaint

If you feel we have violated your privacy rights, you can contact:

U.S. Department of Health and Human Services
Office for Civil Rights
Phone: (800) 368-1019
Website: www.hhs.gov/ocr/privacy/hipaa/complaints/
You can also contact our office directly:
Key Myofunctional Therapy, LLC
Phone: (910) 850-6170 Email: info@keymyo.com
We will not retaliate against you for filing a complaint.
Effective Date: June 7, 2025
At Key Myofunctional Therapy, LLC, your privacy and the security of your personal information are of utmost importance. This policy explains how we collect, use, store, and protect your information when you schedule a consultation, receive care, or communicate with us electronically.

1. Information We Collect

When you request or schedule a consultation (including free 30-minute consultations), we may collect the following personal information:

- Full name
- Email address
- Phone number
- Reason for consultation or brief notes (optional)
- Preferred date/time of consultation

We do not collect protected health information (PHI) through the website beyond what is necessary for scheduling purposes.

2. How We Use Your Information

The information you provide is used strictly to:

- Schedule and confirm appointments
- Contact you regarding your consultation or care
- Respond to inquiries submitted through the website

We will never sell, rent, or share your information for marketing purposes.

3. Data Protection & Security

- Our website uses HTTPS encryption to ensure secure data transmission.
- We take reasonable steps to protect your personal information.
- Email correspondence is sent through a HIPAA-compliant platform: .

Important: Website forms, email, and text messages are not substitutes for fully encrypted medical communication. Please avoid sending sensitive health information via these methods.

4. Electronic Communication Consent

By consenting to electronic communication, you understand and agree that:

- **Permitted Channels:** We may communicate via phone, voicemail, SMS, email, secure client portal, and telehealth platforms.
- **Risks:** These methods may not be fully secure and could be intercepted, misdirected, or accessed without authorization.
- **Sensitive Updates:** If you send personal updates (e.g., medical, emotional, or life events), you do so at your own risk. We may acknowledge these messages briefly, but full discussion will take place in scheduled sessions.
- **Record Keeping:** Messages relevant to your care may become part of your clinical record.
- **Boundaries:** We cannot provide full treatment advice through email/text. Sessions or secure platforms are required for clinical feedback.

You may **opt out** of electronic communications at any time without affecting your access to care.

5. Social Media Policy

- We do not connect with clients through personal social media (e.g., Facebook, Instagram).
- You may follow our professional business accounts, but these interactions do not replace therapy or clinical communication.
-

6. Scheduling Through Third-Party Platforms

If you book your consultation using an integrated third-party scheduler (e.g., Calendly, SimplePractice), your data may also be subject to that service's privacy policy. We encourage you to review their terms.

7. Your Rights

You have the right to:

- Request correction or deletion of your contact information
- Inquire about how your data is used or stored
- Opt out of future communications

To request changes, contact:

8. Changes to This Policy

We may update this policy periodically to reflect operational or legal changes. The most current version will always be available at **keymyo.com**.

Contact Us

Crystal Butler, BSDH, OMT Owner, Key Myofunctional Therapy, LLC
info@keymyo. keymyo.com

6. Acknowledgment of Receipt of Notice of Privacy Practices

Federal law requires that all healthcare providers provide patients with a **Notice of Privacy Practices (NPP)**. This notice describes how your medical information may be used and disclosed, and how you can access your information.

By signing below, you acknowledge the following:

- I have received and reviewed the **Notice of Privacy Practices** provided by **Key Myofunctional Therapy, LLC**.
- I understand this notice explains how my protected health information (PHI) may be used and shared.
- I understand I may request restrictions on the use or disclosure of my PHI and that such requests must be submitted in writing.

If you have questions about your rights under HIPAA or this notice, please speak with your therapist or contact our office.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

Parent/Guardian (if minor): _____ **Date:** _____

Optional Authorization to Share My Information

If you would like us to discuss your care or share your records with a family member, caregiver, or other person, please complete the section below:

I authorize Key Myofunctional Therapy, LLC to discuss my care and/or share my health information with the following person(s):

Name: _____

Relationship: _____

Phone Number: _____

☐ Discuss all aspects of care, scheduling, and billing
☐ Limit access to: _____

This authorization may be revoked by me in writing at any time.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

Parent/Guardian (if minor): _____**Date:** _____

7. Authorization for Release of Information

I authorize Key Myofunctional Therapy, LLC, Orofacial Myofunctional Therapy to release or obtain my health information from the following provider(s) as needed to support coordination of care, case consultation, or continuity of treatment. This includes verbal, written, or electronic communication as appropriate.

Provider Name/Practice: _____

Address/Email/Fax: _____

Purpose: ☐ Continuity of care ☐ Referral ☐ Other _____

Information Requested (completed by Cape Fear Smiles):

☐ Recent evaluation notes, diagnosis codes, imaging reports, relevant treatment summaries
☐ Orthodontic/Dental treatment plan ☐ Orthopedic/Physical therapy treatment plan ☐ ENT or sleep study findings, or other pertinent documentation.
☐ SLP treatment plan, special needs for patient

Response Area (completed by provider):

_____

_____

_____

Treatment Clearance:

☐ This patient is cleared to begin orofacial myofunctional therapy with no limitations.
☐ This patient is cleared to begin therapy **with the following limitations:**

_____

☐ This patient is **not cleared** for therapy at this time. Additional medical or dental referral recommended.

Relevant Co-Managed Conditions (please describe):

_____

_____

This authorization is valid for one year and may be revoked in writing.

Signature: _____ **Date:** _____

8. Medical History

Please list any relevant medical history below. This information helps us ensure safe and effective care.

Current Medications
Please list all prescribed, over-the-counter, or herbal medications you are currently taking.

Medication Name ☐ None	**Dosage**	**Reason Taken**

Allergies
Please list any known allergies, including medications, foods, or environmental allergens.

Allergy ☐ None	**Reaction**

Medical Conditions
Please check any that apply and provide details where needed.

☐ Asthma ☐ Sleep Apnea ☐ ADHD/ADD ☐ Anxiety/Depression

☐ Acid Reflux ☐ TMJ Disorder ☐ Sinus Issues ☐ Seizure Disorder

☐ Heart Condition ☐ Diabetes ☐ Thyroid Condition ☐ None

☐ Other:
_____

Details:
_____

_____

Surgical History
List any surgeries (especially ENT, dental, or airway-related procedures).

Surgery ☐ None	**Date**	**Notes**

Additional Information
Please include any additional notes or relevant health concerns:

9. Birth and Development History

Type of Birth:

☐ Vaginal ☐ C-Section ☐ Assisted (Forceps/Vacuum)

Postpartum Complications:

☐ None ☐ Torticollis ☐ Plagiocephaly ☐ Other: _____

Early Feeding History:

Breastfed: ☐ Yes ☐ No ☐ Difficulty Latching ☐ Reflux ☐ Colic

Bottle-fed: ☐ Yes ☐ No ☐ Difficulty with Transition ☐ Prolonged Use

Check all that apply. Add details in margins or back of form if needed.

Airway & Breathing

☐ Chronic nasal congestion ☐ Seasonal allergies ☐ Sleep apnea / snoring

☐ Enlarged tonsils/adenoids ☐ Mouth breathing ☐ None

Orofacial & Musculoskeletal History

☐ TMJ pain or clicking ☐ Forward head posture ☐ History of orthodontics

☐ Jaw pain or tightness ☐ Frequent headaches ☐ None

Sleep & Behavior

☐ Restless sleep ☐ Bruxism (teeth grinding) ☐ Frequent nighttime waking

☐ Bedwetting (if pediatric) ☐ Daytime fatigue ☐ None

Oral Habits

☐ Thumb/finger sucking ☐ Pacifier use (past or current) ☐ Nail biting

☐ Cheek/lip biting ☐ Tongue thrust ☐ None

Swallowing & Speech

☐ Speech delay or articulation issues ☐ Tongue thrust swallow

☐ Difficulty chewing or swallowing ☐ Picky eating / texture aversion ☐ None

Surgeries / Trauma

☐ Tonsillectomy / Adenoidectomy (Year: _____)

☐ Frenectomy (Year: _____)

☐ Orthodontic Surgery (Year: _____)

☐ Concussions / Head Trauma (Year: _____)

☐ None

Additional Information
Please include any additional notes or questions

Signature: _____ **Date:** _____

Dear Patient,

Thank you for taking the time to complete these forms and for choosing me to be part of your journey toward better health. I know your time is valuable, and I truly appreciate your effort in preparing for our work together.

It's an honor to support you in improving your function, comfort, and overall well-being. I look forward to getting to know you and creating a personalized plan that aligns with your goals.

Please print and bring these completed forms with you to your comprehensive evaluation. If you do not have the ability to print them, no worries, we can complete everything together at the time of your appointment.

If you have any questions or need assistance, feel free to reach out. I'm here to help.

With gratitude,
Crystal Butler, BSDH, OMT
Key Myofunctional Therapy, LLC
716 Medical Center Dr
Wilmington, NC 28401
(910) 850-6170 | info@keymyo.com