Barnett Therapy Services

795 Executive Drive, Oviedo, Florida 32765
Phone: 407-325-0427

Consent For Evaluation and Treatment of Minors
Acknowledgement of Payment Responsibility
Notice of Privacy Policy

Client: ________________________________ Date of Birth:___________________

_ Consent for Evaluation and Treatment: Since my child has a condition requiring diagnostic evaluation and skilled treatment, I _________________________ do hereby voluntarily consent to such testing and treatment by an employee of Barnett Therapy Services, LLC.

_ Notice: I am aware that Speech and Language Therapy is not an exact science and I acknowledge that no guarantees have been made as to the results of treatment.

_ Payment: I understand that I am responsible for the fees associated with the evaluation and treatment of my child. I understand that at this time Barnett Therapy Services does not accept any forms of insurance but will provide an invoice with the applicable information that I may submit to my insurance for the purposes of reimbursement, but that reimbursement is not guaranteed.

_ Cancelation and No Show Policy: If you are unable to make your scheduled appointment, we ask for 24 hour notice so that your appointment time may be given to another client. A $55 fee will be required before the next scheduled therapy session for not showing up to a scheduled appointment or canceling with less than 24 hours notice. We understand that emergencies or unforeseen illnesses occur, but we ask that you respect our policies and the therapists' time. If a client fails to appear without contacting us for three scheduled appointments or cancels an excessive number of times, therapy may be discontinued.

_ Confidentiality: I have read, fully understand and accept the terms of Barnett Therapy Services' HIPAA Compliance Notice and Protected Health Information Release Policy.

Signature of Responsible Party____

Relationship to Client _______________________________ Date ________________