Consent to Evaluate/ Treat

Client Name: _____ Date of Birth:_____ CA: _____
(For Office Use)

Address: _____ Daytime Phone:_____
_____ Cell Phone: _____
Email: _____

Social Security #: _____
Primary Insurance Company:_____ **Medicaid:** ☐ **Yes** ☐ **No**
Primary Insurance #: _____

Secondary Insurance Company:_____ **Medicaid:** ☐ **Yes** ☐ **No**
Secondary Insurance #: _____

***Please text, email, or fax images of all medical insurance cards (front & back.)**
Services cannot begin if we do not have this on file!!!
Email: Info@speakeasytherapyfactory.com **Text:** (803) 400-6334 **Fax:** 803-470-4709

Primary Care Physician Name:_____ Physicians Phone:_____
Physicians Address: _____
Referred by:_____ Phone:_____

This form is to verify that the above individual, consents to be evaluated and/ or treated by SpeakEasy Therapy Factory to determine necessity for, and frequency/duration of ST, PT or OT services. If you agree to this evaluation, a licensed, certified Speech- Language Pathologist, Physical or Occupational Therapist will perform a diagnostic evaluation (including standardized and non- standardized testing, swallow exam, and/ or clinical observations) and provide subsequent treatment, if needed. Therapy goals will be determined based upon the results of the evaluation, the recommendations of the evaluating therapist, and caregiver input.
*Completion of this form will allow us to verify your benefits, so we can discuss insurance payment and any fees/ co- pay charges after insurance coverage is applied. SpeakEasy Therapy Factory **CANNOT** provide services without verification of insurance and/ or an agreement on a payment plan if necessary.

I hereby give consent to be evaluated and/ or treated by SpeakEasy Therapy Factory

_____
Clients Name (Printed)

_____
Caregiver/Parent/Guardian Name (Printed)
(If client under 18 years of age, or cannot sign)

_____ _____
Client/Caregiver/Parent or Guardian Signature **Date**

Please return this competed form to SpeakEasy Therapy Factory prior to initial visit via fax or email.
Email: info@speakeasytherapyfactory.com Fax: 803-470-4709 Phone/Text: 803-400-6334

Acknowledgment of Receipt of HIPAA Privacy Notice

SpeakEasy Therapy Factory, LLC is required by law to keep your health information safe.
This information may include:

Personal/ Identifying information
Your medical history
Insurance information
Notes from your health care provider, teachers and/ or other therapists
Your evaluation and/or test results
Treatment/ therapy notes

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.

By signing this form, you are stating that you have received a copy of our privacy notice.

_____
Clients Name (Printed)

_____ _____
Signature **Date**

OR

_____
Parent/Guardian/ Caregiver Name (Printed)
(If client under 18 years of age, or cannot sign)

_____ _____
Parent/Guardian/Caregiver Signature **Date**
(If client under 18 years of age, or cannot sign)

Person completing form:_____ Relationship to client:_____
Phone#:_____

Please return this competed form to SpeakEasy Therapy Factory prior to initial visit via fax or email. Thank you!

info@speakeasytherapyfactory.com **Fax: 803-470-4709 Phone: 803-400-6334**

Scheduling, Cancellation & Attendance Policy

Scheduling:

Your assigned therapist will reach out to schedule a day and time of the week which works for you both. Please respond to calls, emails and or text messages to schedule and to confirm therapy sessions as soon as possible. *(It effects other children who need services scheduled, when there is a delay in responding about appointment times & days.)*

No Call- No Show's: *(3 NCNS's within a 2- month period will result in an automatic discharge)*

- Failure to respond to calls, or texts to schedule/ confirm appointments
- Not informing therapist of a change to appointment at least 2 hours prior to the start of a scheduled session
- Client is not home or is unavailable for scheduled visit when therapist arrives

Canceled Sessions: *(Please Initial each)*

_____ Please call, text, or email as soon as possible, but at minimum of 2 hours prior to an appointment if you need to cancel or reschedule. *(It will otherwise be considered a NCNS)*

_____Appointments may be canceled or rescheduled if the child is ill, or if a family emergency arises. **Please inform your therapist ASAP and adhere to the 2-hour minimum time window.** The therapist and parent will then agree on a time and date to reschedule the missed session(s).

_____**If you cancel your session using the" text message confirmation" feature, please ALSO contact your therapist via phone, text or email to discuss the cancellation, and to schedule a make- up visit.**

_____**All insurance companies and BabyNet are informed of missed visits as a result of No Call- No Show's.** It is required for SpeakEasy Therapy Factory to report this information to them. Missed visits are taken into consideration by the insurance companies and can negatively impact their decision to grant additional therapy visits, which need to be renewed every few months.

Parent/ Caregiver Attendance:

It is highly recommended that the child's parent(s) or caregiver(s) remain for the duration of the session. It is critical to the success of the child's progress, for caregivers to exhibit knowledge and understanding of therapy techniques to carryover with the child between sessions. The more a child practices what they learn in therapy with family, peers, and caregivers, the faster they will improve.

Your Therapist Contact:

Name:_____ Email:_____@speakeasytherapyfactory.com
Phone: _____ Office Email: info@speakeasytherapyfactory.com

By signing this form, you are confirming that you have been given a copy, and that you understand and agree to the scheduling, cancellation & attendance policy.

_____	_____	_____
Clients Name (Printed)	**Parent-Guardian/ Caregivers' Signature**	**Date**

Allergy Alert Form

Name: _____ **Date:** _____

Date of Birth:_____

Person to Contact in Case of an Emergency: _____

Phone Number:_____ Secondary Phone #: _____

Does the client have any known allergies (e.g., to foods, medicines, environmental agents)? ☐ Yes ☐ No
If yes, please list each allergen and descibe the clients response to contact with the allergen(s). _____
_____
_____
_____
_____
_____

Please describe immediate action to be taken in case of contact with allergen(s). _____
_____
_____
_____

Does the client own an Epi- Pen? ☐ Yes ☐ No
If so, will it be available for use during therapy sessions if needed? ☐ Yes ☐ No
Do you give SpeakEasy Therapy Factory permission to administer the Epi- Pen if neccesary? ☐ Yes ☐ No

Person completing form:_____ Relationship to client:_____
Signature:_____ Date:_____ Phone#:_____

Please return this competed form to SpeakEasy Therapy Factory prior to initial visit via fax or email. Thank you!

info@speakeasytherapyfactory.com **Fax: 803-470-4709** **Phone: 803-400-6334**

Additional Information Form

Name: _____ **Date:** _____

Date of Birth:_____

Person to Contact in Case of an Emergency: _____

Phone Number: _____ Secondary Phone #: _____

Client Interest's

Please list the clients' favorite cartoon characters, books, television, or you- tube shows.

_____

_____

_____

_____

Please list the clients' favorite toys, games, interests & or hobbies.

_____

_____

_____

_____

_____

Person completing form: _____ Relationship to client: _____

Signature: _____ Date: _____ Phone#: _____

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