

Consent to Release / Obtain Information / Payment / Treat

Information regarding your child, including current and past medical history is necessary to develop an accurate profile of my child prior to treatment. At no time will this information be shared outside of this office or for any reason outside of the scope of your child's treatment at Charlotte Speaks without your expressed written consent.

☞ I have been informed of the use and release of information collected through services received in regards to: _____ (*your child's name*). I request that copies of information regarding my child be released to Charlotte Speaks for the purposes of determining the most appropriate course of treatment for my child.

_____ (initial)

☞ I request that payment of authorized Medicaid and / or third party payor benefits be made to Charlotte Speaks on my behalf for services furnished to the child listed above. I authorize Charlotte Speaks to release any medical information about my child, listed above, that may be needed to determine these benefits payable for related services.

_____ (initial)

☞ I acknowledge that any services provided that are not paid for by my private insurance, including NC Medicaid, is my responsibility.

_____ (initial)

☞ I consent to have my child treated by Charlotte Speaks for Speech, Physical, and / or Occupational Therapy Services.

_____ (initial)

Please Print Full Name of Parent / Legal Guardian

Patient/Parent or Guardian Signature

Date

Witness

Date