Consent to Screen, Evaluate, and/or Provide Therapy Services

Child's Legal Name: _____ Date of Birth: _____ □ Male □ Female

Address: _____

How did you hear about us? _____

Who does the child reside with? _____

Who has legal custody of the child? _____

Who is the primary emergency contact? _____

What is your Primary Concern for Treatment? _____

Additional Medical Diagnoses or Concerns: _____

_____

Guardian #1 Name: _____

Guardian #1 Address (if different): _____

Primary Phone: □ Home □ Work □ Cell _____ Preferred Email: _____

□ I grant permission to receive text messages on Guardian #1 primary phone. ___ (Guardian #1 Initial)
□ I grant permission to receive voicemail messages on Guardian #1 primary phone. ___ (Guardian #1 Initial)
□ I grant permission to receive unencrypted emails at Guardian #1 preferred email address. ___ (Guardian #1 Initial)

Guardian #2 Name: _____ Date of Birth: _____

Guardian #2 Address (if different): _____

Preferred Phone: □ Home □ Work □ Cell _____ Preferred Email: _____

□ I grant permission to receive text messages on Guardian #2 primary phone. ___ (Guardian #2 Initial)
□ I grant permission to receive voicemail messages on Guardian #2 primary phone. ___ (Guardian #2 Initial)
□ I grant permission to receive unencrypted emails at Guardian #2 primary email address. ___ (Guardian #2 Initial)

Primary Care Physician: _____ Primary Care Clinic: _____

Primary Care Physician Address: _____

Primary Care Physician Phone: _____ Primary Care Fax: _____

Referring Physician: _____ Referring Clinic: _____

Referring Physician Address: _____

Referring Physician Phone: _____ Primary Care Fax: _____

Payment Information

□ I desire to self-pay and am not providing health insurance information.

□ I desire to process claims through my health insurance plan and am providing accurate information below & a copy of the front and back of our insurance cards.

Primary Insurance Company: _____ Insurance Company Phone: _____

Insurance Company Claim's Address/City/State/Zip: _____

Policy Holder's Name: _____ Relationship to Client: _____

Policy Holder's DOB: _____ Policy Holder's SSN:_____

Group Name & Number: _____ Policy Number: _____

Secondary Insurance Company: _____ Insurance Company Phone: _____

Insurance Company Claim's Address/City/State/Zip: _____

Policy Holder's Name: _____ Relationship to Client: _____

Policy Holder's DOB: _____ Policy Holder's SSN:_____

Group Name & Number: _____ Policy Number: _____

AUTHORIZATION AND CONSENT FOR TREATMENT

I hereby give Peak Pediatric Therapy, LLC permission to screen, evaluate and/or treat my child. I have provided accurate information regarding my medical care and insurance coverage. Treatment is based upon the findings of the evaluation and the recommendations of the responsible speech-language pathologist. I understand there will be oral, written, and electronic communication between care providers/physicians, insurance companies, and Peak Pediatric Therapy, LLC staff.

I understand that the services will be provided by a Colorado licensed speech-language pathologist and certified by the American Speech-Language Hearing Association (ASHA). If a Clinical Fellow or Student Intern provides services they will be under the direct supervision of an ASHA certified speech-language pathologist. I understand services will be rendered in my home, childcare center, or clinic office location at the discretion of the provider.

Printed Name of Parent/Guardian: _____ Relationship to Client: _____

Signature: _____ Date: _____