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Consent Form

Name of Child: _____ Date of Birth: _____

I, _____, herby consent to the evaluation, treatment, and insurance billing for my child. The assessment may include: observation of the child; formal and informal testing; follow up visits; and ongoing intervention. I understand that the results of the Assessment and the Plan of Care will be discussed with me. I agree to comply with the Plan of Care with the best of my ability for the best outcome for my child. I understand that at any given time I have the right to refuse care and revoke my consent for treatment with *True North Speech*.

I consent to and assume all risks and hazards of and incidental to the participation of the above named child in the activities of *True North Speech*, and agree to indemnify the said organization and its officers, servants, or agents nominated or appointed by or on its behalf against all loss from any claim hereafter made against it, them or any of them by or on behalf of said child and arising directly or indirectly from such participation.

True North Speech deem it their responsibility to provide effective and quality treatments to their families in a safe environment. If a therapist feels that a situation is unsafe for them personally, *True North Speech*, reserves the right to discontinue services.

True North Speech has an obligation and responsibility to their professional guidelines and standards of practice. Therefore, when a child no longer qualifies for services or therapy is no longer effective or productive for various reasons, a discharge summary will be completed with or without an FMP (Functional Maintenance Plan) in place for your child depending on circumstances. It is the right of the caregiver at any time for any reason to request a change in providers.

SESSION PARTICIPATION AND CANCELLATION POLICY CONSENT:

_____I agree to actively participate in the scheduling of my child's session and understand that ***3 unscheduled absences*** may result in discharge from therapy services. In addition, I agree to be available to assist my child's therapist regarding sessions; in the compliance with the plan of care; and following the home exercise program under the direction of my child's therapist.

INSURANCE AND PAYMENT POLICY CONSENT:

_____I authorize *Shira Meltzer*, on behalf of *True North Speech*, to submit claims to any 3rd party funding sources (Autism Funding, Variety, CKNW) on my behalf. In the event that a therapy service is not covered by any other source, I agree to pay *True North Speech* the current rate of service, as per True North Speech's financial policy.

RELEASE OF INFORMATION CONSENT:

_____I authorize, *True North Speech*, to release information to health professionals involved with my child to include: case management providers and insurance companies for processing all medical claims on the patient's behalf through written or verbal communication, via regular mail, electronically or by fax. I agree to receive clinical reports from *True North Speech*, through encrypted email in order to protect its content.

MULTI MEDIA CONSENT:

_____I hereby give my consent for use of photo(s) and video(s) of my child during therapy for presentations, education, research purposes, and social media story telling (such as Facebook/Website/Twitter) to *True North Speech.* I understand that at any time I can revoke my consent for all use or use of a particular item.

_____ I decline to give consent for use of photo(s) and video(s) of my child during therapy. I understand that declining will not impact the quality of speech therapy services that my child receives.

ACKNOWLEDGMENT THAT YOU HAVE RECEIVED OUR PIPEDA/HIPAA PRIVACY POLICY:

_____ *True North Speech is* required by law to keep your health information safe. This information may include documents to and from: your doctor(s); school(s); or other healthcare provider(s). Examples of this health information may include: medical history(s); test results; therapy notes; and insurance information. We are required by law to give you a copy of our PIPEDA/HIPAA privacy notice which provides you more details on how your health information may be used and shared.

Signature of Parent/Guardian_____ **Date**_____

Staff Signature_____**Date**_____