Blue Roots Speech & Language

Meghan Westin M.S., CCC-SLP
Certified Speech Language Pathologist

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Blue Roots Speech & Language is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

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. Please initial as acknowledgment that you have received, read and understood our HIPPA Privacy Notice.

______ I acknowledge that I have received a copy of Blue Roots Speech & Language HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

______ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

______ I understand Blue Roots Speech & Language cannot disclose my health information other than as specified in the notice.

______ I understand that Blue Roots Speech & Language reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

______________________________ ______________________
Signature of Parent/Legal Guardian Date

______________________________ ______________________
Printed Name Relationship to Client

____
Name of Client

Please Note: It is your right to refuse to sign this Acknowledgement.
HIPAA Privacy Notice Acknowledgement

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: ______________________________

______________________ Staff Member Signature

____________ Date

Blue Roots Speech & Language

Meghan Westin M.S., CCC-SLP
Certified Speech Language Pathologist

Attendance / Cancellation Policy

While Blue Roots Speech & Language understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or "no shows". Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, illness, or any other event. The most common cause of lack of progress is inconsistent attendance. Please read thoroughly and initial next to your responsibilities.

_______I am responsible for attending speech/language sessions as scheduled. I understand that **I must maintain an 80% attendance rate**, as measured within a given three-month period, or risk losing my appointment slot.

_______In the event of a cancellation, I will provide as much notice as possible. "Non-emergency" **cancellations require 24-hour notice**. "Non-emergency events" include vacations, play-dates, pre-planned medical appointments, events, lack of babysitter, sports events, or anything that is not designated as an "emergency". **If 24-hour notice is not provided, I will be responsible for the full cost of my session.** "Emergency cancellations are accepted only for illness (fever within the last 24 hours, strep, diarrhea, vomiting, or any highly contagious ailment), illness of a family member, or death in the family. **After 3 emergency cancellations, I understand, that a $25 fee will be charged** for any subsequent emergency cancellations within a calendar year. In the event of an emergency cancellation, I understand that I still must notify the clinic to avoid being charged the "no-show" fee for the **full cost** of my session rate.

_______If you do not maintain an 80% attendance rate, the office will reserve the right to cancel all pending appointments and to **no longer offer services** to you as a client.

I have read, understand, and agree the Blue Roots Speech & Language Attendance/ Cancellation policy and the risks of not adhering to it.

______________________________	______________________
Signature of Parent/Legal Guardian	Date
______________________________	______________________
Printed Name	Relationship to Client
______________________________	
Name of Client	

Blue Roots Speech & Language

Photo/Video Release Form

Photographic Images

I give Blue Roots Speech & Language Permission to take photographic images of my child and use them for the following purposes (check all that apply):

☐ Training and/or educational purposes
☐ Use in marketing materials of Blue Roots Speech & Language (e.g. presentations, brochures, website).
☐ Inclusion on the Blue Roots Speech & Language Facebook Account
☐ Photographs sent to parent/guardian/other via phone.

Audio Recordings

I give Blue Roots Speech & Language Permission to take audio recordings of my child and use them for the following purposes (check all that apply):

☐ Training and/or educational purposes
☐ Use in marketing materials of Blue Roots Speech & Language (e.g. presentations, brochures, website).
☐ Inclusion on the Blue Roots Speech & Language Facebook Account
☐ Audio Recordings sent to parent/guardian/other via phone.

Video Recordings

I give Blue Roots Speech & Language Permission to take video recordings of my child and use them for the following purposes (check all that apply):

☐ Training and/or educational purposes
☐ Use in marketing materials of Blue Roots Speech & Language (e.g. presentations, brochures, website).
☐ Inclusion on the Blue Roots Speech & Language Facebook Account
☐ Video Recordings sent to parent/guardian/other via phone.

***If I checked that I would like photographs, audio recordings and/or video recordings sent via phone, these are the names/phone numbers that I approve:**

Name: ______________________________ Phone Number: ______________________
Name: ______________________________ Phone Number: ______________________

Blue Roots Speech & Language

Meghan Westin M.S., CCC-SLP
Certified Speech Language Pathologist

Consent for Services

Please initial to acknowledge that you have received, read, and understand the Blue Roots Speech & Language Consent for Services.

_____ I authorize Blue Roots Speech & Language to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time from Blue Roots Speech & Language in writing. In addition, Blue Roots Speech & Language may terminate services by notifying me in writing.

_____ I do not give my consent or am withdrawing my consent regarding Blue Roots Speech & Language rendering evaluation and therapy services to the client named below.

_____________________________   _____________________
Signature of Parent/Legal Guardian   Date

_____________________________   _____________________
Printed Name   Relationship to Client

____
Name of Client

Blue Roots Speech & Language

Meghan Westin M.S., CCC-SLP
Certified Speech Language Pathologist

General Acknowledgement of Forms

____ I hereby acknowledge and agree that I have read all of the forms and documents provided to me in connection with evaluation and treatment provided by Blue Roots Speech & Language.

____ I understand the meaning and intent of the provided forms and agree to all content included.

____ I have been given an opportunity to ask questions about the provided forms and all questions I've asked have been answered to my satisfaction by Blue Roots Speech & Language.

______________________________ ______________________
Signature of Parent/Legal Guardian Date

______________________________ ______________________
Printed Name Relationship to Client

____
Name of Client