Core4 Therapy Group
Speech-Language Pathology Services
120 Kentucky Avenue, Suite 110
Lexington, Kentucky 40502
859 225-5424

Statement of Agreement Between Core4 Therapy Group and _____

Core4 Therapy Group's office policies and procedures are outlined below. In order to serve you better we have provided these for you to read and sign. A copy of the signed agreement will be given to you for your records.

Confidentiality
I understand that _____'s personal information, evaluation reports, therapy plans, and progress notes will be kept confidential, unless I sign an Authorization To Release Information Form so that specific information requested can be sent. I have been provided a notice of my privacy rights as required by law, and understand the therapist-patient confidentiality.

Borrowing of Equipment or Materials
I understand that I will be charged in full to cover the cost of replacement of any Core4 equipment or material that is not returned at the discretion of the therapist.

Scheduled Appointments
I understand that scheduled appointment times will be reserved for me, and keeping the appointment is my responsibility. Twenty-four (24) hours advanced notice is required for canceling or rescheduling an appointment. If I am unable to keep my appointment, I will cancel at least 24 hours in advance so my child's reserved time can be made available to someone else. I agree to pay full fee for all cancelations and/or missed appointments not canceled at least 24 hours in advance. If late to an appointment (without a call), the appointment will still end at the scheduled time, but will be billed in full.

Payments
I understand that payment in full is due at the completion of each scheduled appointment unless prior arrangements have been made or insurance is being billed.

Payment may be made via cash, check or credit card. I understand I will be responsible for full payment of any missed appointments that are not cancelled 24 hours in advance.

I understand that if I do not pay my bill, or make arrangement for such payments, I will be responsible for any additional fees or collection costs, including attorney fees, which may accrue in pursuing payment of my balance. If my payment is 60 days past due, 5% will be added to my bill. If my balance is $500 in arrears, my child's therapy will be put on hold until the balance is paid. Returned checks will be charged an additional $25.00 to the amount due.

I would like to use the following form of payment:

_____Bill insurance. I understand I will be responsible to pay in accordance with my insurance coverage or plan. Presently Bluegrass Family Health, Humana, United, and Anthem insurances are accepted.

Insurance company _____
Insurance policy holder _____
Policyholder's birthdate _____
Member number_____
Group number _____
Plan number_____

_____Do not bill insurance

Informed consent for therapy services

By reading and then signing this agreement, I am giving Core4 Therapy Group permission to provide speech-language and/or reading services to _____.

I understand that I may discontinue speech-language and/or reading services at any time.

I have read and understand this Statement of Agreement and agree to its terms.

_____ _____
Signature of Client/Parent/Guardian Date

Address:_____
Phone: home_____ cell_____ work_____

_____ _____
Core4 Therapy Group Date