NORTHEAST NEUROPSYCHOLOGY LLC
BRAIN & BEHAVIORAL HEALTH PARTNERS

INFORMED CONSENT FOR SPEECH-LANGUAGE PATHOLOGY SERVICES

For Parents, Caregivers, or Conservators of Patients

I, _____, hereby authorize and request Northeast Neuropsychology, LLC (NEN) to conduct a speech-language evaluation, and if deemed appropriate, speech-language therapy with

_____, DOB_____. The goals, rationale and procedures have been
(Patient Name)
explained to me.

I understand the issue of confidentiality and its limitations and these have been explained to me. I understand that this evaluation and therapy will be confidential. I understand that NEN must adhere to legal and ethical standards in the management and communication of information related to this therapy and that NEN will exert reasonable care to ensure as much as possible that access to this information will be provided to others only as appropriate.

I hereby authorize NEN to release confidential information as needed to obtain payment from third party payors. I authorize and request NEN to release any and all information, results, opinions, conclusions and recommendations related to this evaluation and/or therapy only to those individuals identified on releases. This release can occur via print, fax, email, phone, or in person. **I understand that I am responsible for payment for all evaluation and/or therapy sessions in full in the event that insurance does not pay for it.**

I have received a copy of my rights regarding privacy of health information and any questions have been answered to my satisfaction.

I understand that the providers at NEN will use their best effort to address the referral question, but that no guarantees or promises can be made with regard to outcome of speech-language pathology treatment.

I have read the above consent. I have had an opportunity to ask any questions regarding these issues and these have been addressed to my satisfaction. I understand and accept this consent.

_____ _____
Signature Date

_____ _____
Witness Date

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