



Payment Agreement
Consent &
Release of Information

I understand that Advantage Speech Therapy Services will bill my insurance company but that any unpaid balances are my responsibility whether denied, partially paid, or not covered by my insurance company. There is a minimum of a \$30 charge for any returned checks.

Initial: _____

I understand that I will be a private pay client and that all invoices must be paid within 2 weeks of receipt of invoice.

Initial: _____

I give consent to have Advantage Speech Therapy provide speech therapy services to my child.

Initial: _____

I give consent for my child's picture/video to be taken (no names) to be used for social media and marketing materials.

Initial: _____

I agree to allow Advantage Speech Services to obtain, release, discuss and/or exchange pertinent information about my child with other therapists and/or medical professionals in order to best treat my child.

Initial: _____

Parent/Caregiver Signature: _____

Date: _____