advantage
speech therapy services

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 may be invoiced for a co-pay, travel, or as a private pay client for invoiced in full. I understand 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 medial 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: _____

Child's Name: _____

Parent/Caregiver Signature: _____ Date: _____