Policies and Procedures

THERAPY POLICIES
Authentic Speech provides a model of care that allows our clients to maximize their potential for progress. Our therapy policies allow us to serve each client by reserving weekly appointments and accommodating the need or request for additional therapy.

Canceled Appointments
24 hours' notice is required for any canceled appointment. Failure to provide 24 hours' notice will result in a $50.00 cancellation fee charged to your account. Exceptions will be made for occasional and unavoidable circumstances, such as sudden illnesses, that do not allow for advance notice.

Attendance
Consistent attendance contributes to effective progress. We expect an attendance rate of at least 85%. Abuse of this policy may be subject to a charge and/or discontinuation of services.

Make-Up Sessions
We encourage our clients to reschedule canceled appointments to ensure consistent service delivery. Your therapist will work with you to reschedule your canceled appointments for planned holidays, vacations, extracurricular events, etc.

No-Show
Our therapists spend time planning and preparing for each therapy session. Missed appointments without prior notice (either directly to the treating therapist or administrative staff) will be charged at the private pay rate. This fee is not billable to health insurance.

______ **I acknowledge receipt of and agree to the therapy policies of Authentic Speech**
Initial **outlined above.**

AUTHORIZATION TO VIDEO/AUDIO RECORD

Authentic Speech may utilize video and/or audio recordings for the purpose of evaluation and treatment. These recordings may be shared with the client's medical professionals, treatment providers, etc. for the purposes of coordinated care.

______ **I grant permission to Authentic Speech to utilize video and/or audio recordings while**
Initial **providing services to me/my child.**

HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

Authentic Speech is required by law to keep your health information safe. This information may include notes from your doctor, teacher, or other health care providers; your medical history; your test results; treatment notes; and insurance information.

Authentic Speech is required by law to give you a copy of our privacy notice. This notice explains how your health information is used and/or shared. It also explains how you can obtain your information and comment on it.

______ **I acknowledge receipt of Authentic Speech's Privacy Notice.**
Initial

PAYMENT AGREEMENT

Authentic Speech's Payment Agreement includes the following:

1. Agreement to pay for services at the time they are rendered;
2. Understanding that the client/guarantor will remain responsible for payment to Authentic Speech for all services provided that are not reimbursed by the client/guarantor's insurance company;
3. Payment shall be sent via electronic transfer of funds, money order or check to account number listed on Authentic Speech invoice; and
4. Any costs incurred by Authentic Speech for any returned checks or insufficient funds is the client/guarantor's responsibility.

______ **I acknowledge receipt of and agree to the Payment Agreement outlined above.**
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CONSENT TO TREAT VIA TELETHERAPY

1. I have the right to withhold or withdraw my consent to teletherapy, in writing, at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information (HIPAA) also apply to teletherapy, as do all other applicable Company policies, e.g. Payment Agreement.
3. I understand that through no fault of the Company there are certain unavoidable risks associated with engaging in teletherapy, including, but not limited to: the transmission of my information could be disrupted or distorted by technical failures; the transmission of

my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. I understand that teletherapy based services and care may not be as complete as face-to-face services. Should the Company, in consultation with the client's treating therapist, make a clinical judgment that teletherapy services are not effective, the Company reserves the right to discontinue teletherapy in accordance with "best practice" standards and refer the client to in person therapy services.
5. I understand that I/my child may benefit from teletherapy, but that results cannot be guaranteed or assured.
6. If I have concerns regarding teletherapy, I will direct my concerns, in writing, to kristinah@authenticspeechllc.com.
7. I understand that I am responsible for: (1) Providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) Ensuring information security on my computer, and (3) Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my/my child's teletherapy session.

______ **I acknowledge receipt of and agree to the Consent to Treat Via Teletherapy outlined**
Initial **above.**

In consideration for the professional services rendered to me or my child, by Authentic Speech, I acknowledge receipt of and agree with Authentic Speech's Policies and Agreements outlined above.

______________________________ ______________________________
Client Signature Date

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(Printed) Client Name