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Manalapan, NJ, 07726
Logopedllc@gmail.com
Logopedllc.com
(917) 991-9590

LOGOPED LLC
SPEECH-LANGUAGE PATHOLOGY

Patient Consent Form

I hereby authorize **Logoped LLC**, to directly receive payment of relevant insurance benefits; to release information including protected health information (PHI) to insurance companies and other related third parties as needed in relation to the filing for or collection of payment for provided services; to obtain records from other sources as needed in relation to patient diagnosis and treatment; and to convey information through various means as needed in accordance with the Notice of Privacy Practices, a copy of which was made available to me.

I hereby acknowledge that I am personally responsible for all co-payments, deductibles, non-covered services, and required referrals according to my insurance policy. I agree to pay all applicable charges accrued and to promptly pay any balance in full. If my insurance does not pay within 120 days, I understand that I will be held personally responsible for any balance. I understand that my account will be charged $25.00 for any checks returned due to non-sufficient funds. I agree to promptly alert **Logoped LLC** should there be any changes related to insurance and other information I provided above 30 days prior to occurrence.

With my consent, **Logoped LLC** may e-mail (_____) and/or contact me by my cell (_____)_____-_____ or home (_____)_____-_____ number and leave a message on voicemail in reference to appointment reminders, insurance items, billing items, and any call pertaining to clinical care including test results.

With my consent, **Logoped LLC** may mail to my home or other designated location any items that assist them in carrying out treatment, payment, or health care operation (TPO) such as appointment reminder cards, patient statements, and test results as long as they are marked Personal and Confidential.

Name and Signature of Responsible Party: **Date:** _____

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