



### SPEECH PATHways Client Registration

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone #1: \_\_\_\_\_

Cell Phone #2: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Employer/Address: \_\_\_\_\_

\_\_\_\_\_

Primary Care

Physician/Address/Phone: \_\_\_\_\_

\_\_\_\_\_

Diagnosis (Reason for Treatment): \_\_\_\_\_ Onset Date: \_\_\_\_\_

I certify that the above information is true. I will notify SPEECH PATHways of any changes to the above information.

\_\_\_\_\_  
**Print Patient's Name**

\_\_\_\_\_  
**Patient Signature or Responsible Party**

Thank you for choosing SPEECH PATHways for your speech-language pathology services.



## SPEECH PATHways Consent for Treatment

This agreement will serve as notification that payment for all therapy services is due and payable at the time of service or in advance through our monthly credit card billing option. You will receive a monthly itemized “superbill” statement for your records. It will be your responsibility to submit and pursue insurance reimbursement if these services are covered. SPEECH PATHways is not accepting or billing your insurance carrier. Payment can be made via cash, check or credit card.

In the event that you need to cancel or reschedule 24 hour notice is appreciated. Please see the SPEECH PATHways cancellation policy for complete details on charges that may apply in the event that 24 hour notice is not provided.

If you wish reports to be submitted to your physician, you must complete the information below:

Doctor’s name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

If all terms above are agreeable and acceptable please sign below. By signing you are hereby consenting to treatment.

\_\_\_\_\_  
**Patient’s Name**

\_\_\_\_\_  
**Responsible Party (if minor)**



December 1, 2006

Dear Client:

Effective January 1, 2007, SPEECH PATHways will be increasing the fee for less than 24-hour cancellation notice and/or no-show appointments to \$60.00. SPEECH PATHways will be willing to make exceptions to this policy only in rare, extenuating circumstances. Please keep in mind that careful planning and preparation goes into your child's therapy session. When a session is missed, it leaves an open therapy spot for another child/client who would benefit from SPEECH PATHways services. In addition, consistency is crucial in the remediation of speech and language deficits.

In the event that attendance becomes a chronic issue, you will be required to pay for the entire session fee if you wish to maintain your current treatment time. This policy will only be instituted as a result of a high frequency of last minute cancellations and/or no show appointments. You will be notified in writing if this policy is to be implemented.

Please complete the bottom portion of this letter and return to SPEECH PATHways. Your therapist can provide you with a copy of this signed document for your records. If you have any questions regarding this matter, I would be happy to discuss it with you.

*Kim*

Kimberly A. Bell, M.S., CCC-SLP  
Owner/Speech-Language Pathologist  
[kim.bell@speechpathways.net](mailto:kim.bell@speechpathways.net)

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I \_\_\_\_\_, understand that there will be a \$60.00 fee for less than 24-hour cancellation notice and/or no-show appointments after January 1, 2007.

The fee for missed appointments must be collected prior to (or at) your next scheduled appointment if you pay via check or cash. If you have a credit card on file, your credit card will be billed directly for the missed appointment.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Patient or Guardian Signature**

\_\_\_\_\_  
**Date**

## Check Return Policy

There will be a \$25.00 charge for all returned checks for non-sufficient funds. The sum of the original check plus the \$25.00 NSF charge must be received prior to any further visits.

By signing you are agreeing to the above terms.

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**Patient's Name**

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**Signature of Responsible Party**



Dear Clients,

SPEECH PATHways does not automatically follow the Carroll County School Inclement Weather Policy for closings and delays. Please check directly with your therapist to see if SPEECH PATHways is open on a particular day by contacting the Westminster Clinic at 410-386-0199.

We have found that many times the roads have been cleared by the time we begin services in the evening. If your appointment time is in the morning (prior to noon) and the Carroll County Schools are closed then your appointment will be cancelled or rescheduled. We will make every attempt to see your child when deemed safe and appropriate in relation to the weather conditions.

Sincerely,

*Kim*

Kimberly A. Bell, M.S., CCC-SLP  
Owner/Speech-Language Pathologist