American Speech-Language-Hearing Association
Certified Member

Metro Speech Therapy

*10810 Darnestown Road (suite 102), N. Potomac, MD 20878 *727 Lake Varuna Drive, Gaithersburg, MD 20878 * Phone/Fax: (240) 200-5035

Anat Sohn, M.A., CCC-SLP

Metro Speech Therapy, LLC

Pediatric and Adult Speech-Language Pathologist

MD License Number: 05839

Dear _____,

This packet contains forms to be completed and returned by mail or fax prior to your appointment. Please return all forms by mail or fax one week prior to the evaluation or treatment date. If you fax the forms, please bring the originals on the date of the appointment. If you have additional information, such as school or therapy reports, please forward those as well. Should you have questions about the completion of these forms, please call (240) 200-5305.

Please return forms to:

Anat Sohn, M.A., CCC-SLP

Metro Speech Therapy, LLC

10810 Darnestown Road, N. Potomac, MD 20878

Fax #: (240) 200-5305

Sincerely,

Anat Sohn, M.A., CCC-SLP

Please make sure to complete the following items to help prepare for the evaluation or initiation of treatment.

- ____ Complete the packet.
- ____ Send or fax the completed packet. If the packet is faxed please bring original forms to evaluation/ treatment date.
- ____ Send other relevant reports.

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Payment for Services

For your convenience, we accept cash, checks, credit cards and debit cards. Payments will be made at the time of service and a receipt will be sent to you via email.

Please sign and return the Credit Card/ Debit Transaction Form along with the remainder of the forms. All correspondences regarding billing should be mailed to this address:

Anat Sohn, M.A., CCC-SLP
Metro Speech Therapy, LLC
10810 Darnestown Road, N. Potomac, MD 20878
Fax #: (240) 200-5305

Cancellation and No-Show Policy

Cancellations with less than 24 hours from your scheduled appointment will be billed $30. For all cancellations, please call (240) 200-5305.

We greatly appreciate as much advanced notice as possible of vacations or other events for which you are unable to keep your appointment.

Appointments that are not cancelled are considered "no-shows". These appointments will be billed at the full rate and the client will be responsible for full payment.

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Credit Card/ Debit Transaction Processing Authorization Form

_____ Yes, I would like you to automatically charge my credit card for services rendered.

CARD TYPE **NUMBER** **EXP. DATE** **3 DIGIT CODE ON BACK**

_____*Visa* _____ _____ _____

Billing Address and Name on the card: _____
_____
_____

CARD TYPE **NUMBER** **EXP. DATE** **3 DIGIT CODE ON BACK**

_____ *MasterCard* _____ _____ _____

Billing address and Name on the card: _____
_____
_____

CARD TYPE **NUMBER** **EXP. DATE** **4 DIGIT CODE ON FRONT**

_____ *American Express* _____ _____ _____

Billing address and Name on the card: _____
_____
_____

By signing this Agreement, and marking the box noted above, the undersigned does hereby agree as follows: (i) the undersigned does hereby authorize and agree that Anat Sohn, M.A., CCC-SLP and/or its duly authorized agent (Metro Speech Therapy, LLC) has the right to charge to the above identified credit card and/or debit the account identified above any and all amounts that are owed to the Company and/or its consultants, (ii) the undersigned agrees that its signature on this Agreement shall be deemed its signature on any sales charge receipt or other form and if any merchant services, credit card company, or bank requests to view the undersigned signature on a sales charge receipt or other form, the Company may provide such company with a copy of this Agreement and such shall be deemed conclusive proof that the undersigned approved and authorized the charge and/or debit at issue, and the undersigned does hereby waive any right to dispute its authorization to such charge based on an invalid or non-existent signature. The undersigned understands and agrees that the above payment option and charges or debits will continue each month for services rendered by the Company and/or its consultants until such time as the undersigned has provided written notice to the Company to stop such automatic charges and/or debits. The undersigned shall be fully responsible for ensuring that it has sufficient credit and/or funds to cover the charges or debits, and shall indemnify the Company against all costs incurred as a result of any declined charge or debit.

AGREED AND ACCEPTED

Cardholder's Signature: _____

Print Name: _____

*All credit and debit cards will be processed at the time of service.

Date: _____

I, _____ authorize Anat Sohn, M.A.,CCC-SLP to send paid invoices via

electronic mail to _____(email address).

Signature: _____ Date: _____

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I, _____(*print name*), acknowledge and accept full and complete responsibility for payment of all services rendered by Metro Speech Therapy, Anat Sohn, M.A., CCC- SLP, and/or its consultants. I acknowledge that I have received written explanation of the cancellation policy and payment policy and I agree to both.

I understand that health insurance policies are an arrangement between my insurance company and myself, that all services rendered are charged directly to me, and that I am personally responsible for payment. I understand that agreements regarding fee schedules, charges for cancelled appointments and late payment fees are between Metro Speech Therapy, LLC and myself and are not related to potential insurance coverage. I understand that Anat Sohn, M.A., CCC-SLP may assist me in completing forms to aid in collecting insurance benefits for services that are billable, but ultimately it is my responsibility to complete and file such forms. I agree to the release by Metro Speech Therapy, LLC and/or its duly authorized agents of any information that is requested by my insurance company.

_____

Date

_____

Signature of client /(parent or legal guardian)

_____

Print Name

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Agreement to Terms of Payment (insurance)

I, _____(*print name*), acknowledge and accept full and complete responsibility for payment of all services rendered by Metro Speech Therapy, Anat Sohn, M.A., CCC- SLP, and/or its consultants that are not covered by my health insurance plan. I acknowledge that I have received written explanation of the cancellation policy, and payment policy and I am in agreement.

I understand that I am responsible for my copay at the time services are rendered and Metro Speech Therapy, LLC will submit claims to my health insurance company on my behalf. I understand that all payments on claims that are denied by my health insurance company are my responsibility and that all services rendered that are not covered by my health insurance company are charged directly to me. I understand that agreements regarding fee schedules, charges for cancelled appointments and late payment fees are between Metro Speech Therapy, LLC and myself and are not related to potential insurance coverage. I understand that Anat Sohn, M.A., CCC-SLP will complete forms on my behalf in collecting insurance benefits for services that are billable. I agree to the release by Metro Speech Therapy, LLC and/or its duly authorized agents of any information that is requested by my insurance company.

_____

Date

_____

Signature of client /(parent or legal guardian)

_____

Print Name

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INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Insurance Company Phone# (Provider line): _____

ID #: _____ Group #: _____

Card Holder"s name: _____ Card Holder's DOB: _____

Name of Secondary Insurance Company: _____

Insurance Company Phone# (provider line): _____

ID #: _____ Group #: _____

Card Holder"s name: _____ Card Holder's DOB: _____

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Acknowledgement and Assumption of Risk (adult)

I, _____ (*print name*) acknowledge and agree to receive speech therapy services from Anat Sohn, M.A., CCC-SLP and/or any independent contractor under the foregoing at Metro Speech Therapy, LLC. I acknowledge that there is some risk inherent in the use of the therapy equipment and I agree to assume such risk and indemnify and hold Anat Sohn, M.A., CCC-SLP, any of their independent contractors, and Metro Speech Therapy, LLC harmless from any and all losses and claims for any injuries or other damages occurring to my belongings or myself.

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INTAKE FORM (ADULT)

Name: _____ Date of Birth: _____

Address: _____

Phone#: Home: _____ Cell: _____ Work:_____

Email Address: _____

Please describe your **concerns** and **primary referral reasons**: (Please include any **medications** or **allergies/special diets**:

_____

_____

_____

Briefly describe pertinent medical history such as any **surgeries**, **medical diagnoses** or any **history of seizures** (or attach reports that will summarize the information.):_____

_____

_____

_____

Describe current health status: _____

_____

_____

Please briefly describe any **therapeutic** history you have had:

_____

_____

_____

_____

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Consent to Release Form (adult)

I, _____ (*print name*) give my permission and consent to Metro Speech Therapy, Anat Sohn, M.A., CCC-SLP, and their respective consultants and agents (hereinafter, collectively, the "Company") to discuss and speak with nurses, psychiatrists, medical doctors, other therapists, insurance representatives, and other professionals (collectively, "Third Party Professionals") regarding myself as such may be needed in connection with the treatment and/or evaluation of myself by the Company.

In addition, the Company is authorized to receive any records, files, charts, and other documentation and information from such Third Party Professionals, and by signing this document, the undersigned is authorizing the release of any such information that may be held by a Third Party Professional to the Company. Any person who is provided a copy of this document may rely on it as the undersigned's full and unconditional consent to the release of any and all information pertaining to the client/patient. The undersigned further authorizes the Company to release any and all information pertaining to the treatment and/or evaluation of the client/patient to any Third Party Professional that may in any way be involved in the treatment and/or evaluation of the client/patient.

The undersigned understands that some or all of the information obtained and/or released under this document may be protected under federal regulations including but not limited to HIPAA. By authorizing a release of information, as set forth above, the undersigned understands and agrees that they are agreeing to the release of such information notwithstanding the protections under HIPPA, provided, however, it is understood and agreed that the Company will maintain the confidentiality of any information obtained and will not disclose the same except as needed in the course of treating or evaluating the client/patient.

The undersigned, for his/herself and his or her successors and assigns, does hereby hold the Company harmless from any and all claims relating to the release of information as provided above, and do hereby waive and release any claim against the Company relating to the release of such information as provided above. 9

AGREED AND ACCEPTED:

_____ _____

Signature Print Name

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Consent Form (adults)

NAME	PHONE #	INITIAL & DATE

I, _____ give my permission to Anat Sohn, M.A., CCC-SLP at Metro Speech Therapy, LLC and their consultants (hereinafter, collectively, the "Company") to speak with the above listed professionals regarding myself_____.

_____

Signature

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VIDEO RECORDING ACKNOWLEDGEMENT AND CONSENT FORM (adult)

I, _____(print name), understand that Metro Speech Therapy, Anat Sohn, M.A., CCC-SLP, and their consultants (hereinafter, the "Company") may use video recording and related equipment for diagnostic and treatment planning purposes.

I further consent to the use of the video by the Company for the purpose of training personnel in the health care and education fields. I understand that if the Company uses the video for training purposes, the Company will inform us of this intention. I understand that the Company will protect the family's identity and will disclose only those details about the patient/client's condition and treatment process necessary for training purposes. Accordingly, by signing below, the undersigned does hereby release and waive any and all rights that the undersigned may have in the videos, and assigns such rights to the Company to be used in accordance with the terms of this Consent Form.

_____ _____

Print Name Signature

_____

Date

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GENERAL ACKNOWLEDGMENT OF FORMS (adult)

I do hereby acknowledge and agree that: (i) I have read all of the forms and documents provided to me in connection with the treatment and evaluation of myself) by Metro Speech Therapy, Anat Sohn, M.A., CCC-SLP, and/or their respective consultants; (ii) I understand the meaning and intent of such forms, and agree to the provisions contained therein; (iii) I have been given the opportunity to ask questions concerning the forms and any questions that I have asked have been answered to my satisfaction, and (iv) I have signed all of the forms upon my on free volition and without any coercion from any third party.

_____ _____

Print Name Signature

_____

Date

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PROFESSIONAL CONTACT FORM (adult)

Name: _____ Date: _____ DOB: _____

Referred by: _____

Occupational Therapist: _____
Telephone: _____
Address: _____

Physical Therapist: _____
Telephone: _____
Address: _____

Speech-Language Pathologist: _____
Telephone: _____
Address: _____

Physician: _____
Telephone: _____
Address: _____

Psychologist/Psychiatrist (circle one): _____
Telephone: _____
Address: _____

Neurologist: _____
Telephone: _____
Address: _____

Other Professional: _____
Telephone: _____
Address: _____