RACHEL CORTESE, MS CCC-SLP, MS Ed

SPEECH, LANGUAGE AND BEHAVIOR THERAPY

AUTHORIZATIONS & CONSENTS

(PLEASE PRINT)	
Today's date:	Name of person completing form:

IDENTIFYING INFORMATION					
Child's Last Name:	First:		Birth date:	Age:	Sex:
			/ /		❑ M ❑ F
Street address:	City:	Zip:	Mother's cell phone:		Father's cell phone:
			( )		( )

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE	
Notice of Privacy Practices: It is my understanding that my child's personal information, medical history, notes from doctors, teachers or other health care providers, treatment notes, test results or insurance information will not be shared with any other entity without my prior knowledge. I further acknowledge that the use of this information is to ensure the best quality of care possible for my child. By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about my child may be used.	
Parent/Guardian signature	Date

FINANCIAL RESPONSIBILITY	
I understand that I am financially responsible for any balance at the time of service.	
Parent/Guardian signature	Date

INSURANCE	
I authorize Rachel Cortese, MS CCC-SLP to release any information required by my insurance company to process my claims. If you carry insurance, please understand that our professional services are rendered and charged to you, not to the insurance company. It will be your responsibility to contact your insurance company to determine if they will reimburse you and if so, what percentage of the fee they will cover. You will be provided with an invoice each session with the appropriate diagnosis and treatment codes for your insurance submission.	
Parent/Guardian signature	Date

(OVER)

EMAIL COMMUNICATION	
I consent to have Rachel Cortese, MS CCC-SLP communicate with me via e-mail regarding the following aspects of my child's care and treatment: [test results, appointments, billing, treatment progress and program updates, communication with other professionals involved in my child's care etc.]. I understand that e-mail is not a confidential method of communication.	
Parent/Guardian signature	Date

PRACTICE POLICIES	
I have received, reviewed and agree to adhere to the practice policies.	
Parent/Guardian signature	Date

PHOTO/VIDEO CONSENT	
I understand that from time to time video footage is used for clinical purposes (i.e. as part of evaluation and treatment) and to provide information about the evaluation or therapy sessions. Given your consent, video footage or photographs of my child may also be used for educational purposes (i.e. professional trainings or used on *www.rachelcortese.com*). I understand that I will not be compensated for use of photographs or videos and that my child's name will not be used in connection with any such photographs or videos. I agree to allow my child's picture and/or video to be used for the following purposes (please check all conditions that you give consent for): Clinical Purposes only (i.e. as part of evaluation and treatment) Educational purposes such as professional presentations Shared on *www.rachelcortese.com* for educational and promotional purposes	
Parent/Guardian signature	Date

(OVER)

CONTACTING OTHER PROVIDERS/ AUTHORIZATION FOR RELEASE OF INFORMATION

Communication with other individuals involved in the care and education of your child is essential for your child's growth in therapy and to ensure the best quality of care possible. However, we will not communicate with or share information about a child with his/her tutors, friends, nannies, teachers, doctor, or members of the child's team of therapists without the parents' written consent.

Information that may be used or shared with authorized individuals may include:

- Evaluation or Consultation results
- Treatment progress

I authorize Rachel Cortese, MS CCC-SLP to communicate by phone or email with the following individuals regarding the care of my child:

	Name	Phone Number	Email
Teacher 1			
Teacher 2			
School Psychologist			
Resource Room Teacher/ Tutor			
Speech Therapist			
Guidance Counselor			
Primary Care Doctor			

You may take back this authorization at any time.

This authorization will expire:

On ________________________________ (date)

or

After the following event happens:______________________________(i.e. a child's school meeting, etc.)

Parent/Guardian signature	Date

Rachel Cortese, MS CCC-SLP, MS Ed
Speech, Language and Behavior Therapy
Brooklyn, NY
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