CONSENT TO EVALUATE AND TREAT

A. **Consent to the Treatment**, I authorize Kid Talk Inc. and its employees to provide speech-language, occupational, feeding, literacy, and orofacial myology therapy evaluations and therapy in ways that are beneficial to me. I further authorize Kid Talk Inc. and its employees to render further evaluation or treatment that may be required on a follow-up basis without further consent. I understand my treatment will include evaluations and possibly video taping of evaluation and therapy sessions. No guarantees have been made to me about the outcome of the therapy.

B. **Authorization as To use of PHI,** I may for reasons other than treatment, payment or health care operations authorize Kid Talk Inc. to release medical and statistical information as to my treatment (which does not identify me by name or address) for research, quality assurance, marketing and other related purposes with further authorization from me.

C. **Medicare and/or Medicaid.** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release such information to the Social Security Administration, its intermediaries or carriers if it is needed for this or a related Medicare claim. I request that payment of authorized benefits for Kid Talk Inc.'s services be made on my behalf, and I assign such benefits to Kid Talk Inc. for payment of benefits.

D. **Insurance**. Consent is granted to release such information as may be necessary for the completion of Kid Talk Incs claims to the client's insurance company, and I assign benefits to Kid Talk Inc.

E. **Guarantee of Payment**. I guarantee payment of charges not covered by this consent.

I CERTIFY I HAVE READ THE ABOVE PROVISIONS AND ACCEPT THEIR TERMS.
Assumption of signature for client (per year):

I, _____, have signed for _____

The client could not sign because:_____

_____ _____
(Signature) (Relationship to client, e.g., parent)

_____ _____

I have been offered the HIPAA Notice of Privacy Practice by Kid Talk, Inc. (DL HIPAA Privacy Statement)

Signature

Date

YOUR HEALTH CARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND YOU MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR SERVICES PROVIDED.