The Mouth Matters LLC / Amy Ford, M.S. CCC-SLP
18811 Graystone Road, White Hall, MD 21161
410-562-5114
amyford@themouthmatters.net

Consent for Services

☐ I authorize The Mouth Matters LLC/Amy Ford to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Amy Ford in writing. In addition, Amy Ford may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent regarding Amy Ford rendering evaluation and therapy services to the client named below.

_____ _____
Print Name of Client Date

_____
Client Date of Birth

_____ _____
Signature of Client or Legal Representative Relationship to Client

Payment Policy & Fee Schedule

Thank you for choosing our private practice to serve you. We are committed to providing you with the highest quality care. Please know that the timely payment of your bill is an integral part of our service and as such, this payment policy is an agreement between you and The Mouth Matters LLC for payment of services provided. By signing this policy, you are agreeing to pay for services provided to you or your family member. As a client of The Mouth Matters LLC/Amy Ford you are required to carefully review and sign our payment policy.

Fee Schedule

01/JULY/2025

MYO/FEEDING EVAL	**$450**
LANGUAGE EVAL	**$400**
SPEECH/FLUENCY EVAL	**$400**
SPEECH & LANGUAGE EVAL	**$450**
SPEECH/FEEDING/MYO THERAPY	**$160 per 45 mins**
MYO MATERIALS	**$100 (1x fee)**
APPOINTMENT CONSULTS	**$60 per hour**

Please read the following information carefully:

All therapy fees (including session fees and/or co-pays, if applicable) are due at the time of service.

We accept the following payment methods at this time: Cash, Check, Venmo, or Zelle.

(Checks should be made payable to Amy Ford).

We will provide you with a superbill, upon request, outlining the services rendered and the amount charged.

Please read and check all boxes to acknowledge understanding and the sign below:

☐ I understand that I am responsible for all costs / fees that any third-party payer (ex. insurance company, private school, etc.) does not cover. In the event that a third-party payer source determines that rendered therapy services are “not covered” or otherwise denied, I will be responsible for all outstanding charges. I understand that I will be billed accordingly and will be responsible for immediate payment. I also understand that The

Mouth Matters LLC/Amy Ford will not become involved in disputes between you and your third-party source regarding uncovered charges or reasons for denial.

☐ I understand that if fees are not paid in full, treatment sessions may be postponed or cancelled until payment is received.

☐ I understand that all returned checks will be subject to a $25 returned check fee. Charges incurred and not paid after 30 days may be turned over to a collection agency at the client's expense. Overdue accounts may also be reported to a Credit Bureau.

☐ I understand that I am responsible for all legal and collection fees, which The Mouth Matters LLC/Amy Ford may incur if payment is not made in accordance with the terms and conditions herein.

☐ I understand that refunds will be issued only in instances of overpayment. All refunds will be processed within 2 weeks after the overpayment is discovered on the client's bill or at the time the refund is requested. Refunds for payments made with a credit card will be credited back to the credit card used, all other refunds will be issued by a check. Client's who used a third-party source will not be issued a refund until full payment is received from the appropriate source.

☐ I, understand that all cancellations require 48 hours notice and that there will be a $100 charge for any cancellations made less than 48 hours. This charge is my sole responsibility and will not be covered by a third-party source.

☐ I, _____, (client / guardian name) understand the payment policy and the risks of not adhering to it.

_____ _____
Print Name of Client Date of Birth

_____ _____
Signature of Client, Guardian or Responsible Party Relationship to Client

_____ _____
Private Practitioner / Witness Date

Attendance / Cancellation Policy

Attendance and participation in therapy along with complete compliance with any associated home programs, are essential for therapeutic success.

While The Mouth Matters LLC / Amy Ford understands that illnesses and emergencies occur, we respectfully request that you avoid frequent cancellations or “no shows”. Please adhere to our following policy regarding providing our office with advance notification for any cancellations resulting from a conflicting appointment, vacation, obligations for work or family, or any other event.

All cancellations must be submitted 48 hours prior to your scheduled appointment.

☐ A fee of $100 may be assessed if the following occurs.

- If cancellations are made less than the required 48 hours.
- If the client fails to show up for a scheduled appointment.

☐ If you reschedule / are late for 5 scheduled appointments within 30 days, the office will reserve the right to discharge the client. Additionally, if you arrive late for a scheduled appointment, the session will still end at the scheduled time or may be cancelled.

☐ If you fail to appear for an appointment (no show) without providing the appropriate advance notification for 3 or more appointments within a calendar year the office will reserve the right to cancel all pending appointments and to no longer offer services to you as a client.

☐ I, _____, understand the attendance / cancellation policy and the risks of not adhering to it.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

Authorization to Exchange, Obtain or Release Information

Client Name: _____ Date of Birth: _____
Home Address: _____
_____

I _____ (client or family member) hereby grant The Mouth Matters LLC/Amy Ford permission to communicate with the following person or agency:

Name:

Contact Information:

Information to Be Released:
☐ Medical History
☐ Therapy Evaluation
☐ SLP ☐ OT ☐ PT ☐ Other: _____
☐ Treatment Notes
☐ SLP ☐ OT ☐ PT ☐ Other: _____
☐ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of: (check all that apply)
☐ Coordinating care with other professionals
☐ Providing continuity of services
☐ Updating therapeutic progress
☐ Other _____

☐ I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.
☐ I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

Consent and Release of Photographs / Videos

☐ I, _____ (client or parent/guardian name) give consent to The Mouth Matters LLC or any party authorized by The Mouth Matters LLC to photograph and/or video record _____ (client name) in connection with his/her therapy sessions, for any purpose subject to the therapist's discretion including but not limited to teaching purposes and demonstration of progression of his/her skills.

☐ I authorize The Mouth Matters LLC to use pictures of _____ (client name) for promotional purposes (ex. brochures, website, etc.)

☐ I acknowledge that I will receive no financial compensation for providing consent since my participation with The Mouth Matters LLC in providing my consent and release is voluntary.

☐ I hereby release The Mouth Matters LLC, their contractors, their employees and/or any third parties involved in the creation or publication of The Mouth Matters LLC. Publication from any and all liability that may arise in connection with the expressed and implied use of all photographs and videos outlined in this form.

☐ I reserve the right to revoke this agreement at any time. I understand that my right to revoke must be done in writing.

I am the client, parent or legal guardian of the person named below and have the legal authority to execute this consent and release.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

Acknowledgement & Assumption of Risk

☐ I, _____ (client or parent/guardian name) understand that I am being asked to carefully read each of the provisions in this form. I acknowledge and agree to have _____ (client name) receive therapy services from The Mouth Matters LLC / Amy Ford, M.S. CCC-SLP and/or any employee or independent contractor employed by The Mouth Matters LLC / Amy Ford, M.S. CCC-SLP.

☐ I acknowledge that there is some inherent risks associated with the use of therapy equipment that cannot be eliminated regardless of the care taken to avoid injuries.

Some of the unlikely but potential injuries include:

Any equipment that is used within the oral cavity could result in gagging, choking, mild abrasions, and/or an allergic reaction to materials.

I understand the risks and I hereby assert that my participation is voluntary and that I knowingly assume such risks without holding The Mouth Matters LLC / Amy Ford, M.S. CCC-SLP and/or any employee or independent contractor employed by The Mouth Matters LLC / Amy Ford, M.S. CCC-SLP accountable for any losses, injuries or other damages occurring to the client and/or myself. I further understand that I am fully responsible for my own safety.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client

General Acknowledgement of Forms

☐ I hereby acknowledge and agree that I have read all of the forms and documents provided to me in connection with evaluation and treatment provided by The Mouth Matters LLC/Amy Ford and/or their employees.

☐ I understand the meaning and intent of the provided forms and agree to all content included.

☐ I have been given an opportunity to ask questions about the provided forms and all questions I've asked have been answered to my satisfaction by The Mouth Matters LLC/Amy Ford.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

HIPAA POLICY
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health

information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services Office of
Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Acknowledgement That You Have Received Our HIPAA Privacy Notice

Amy Ford, owner of The Mouth Matters LLC, is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

☐ I acknowledge that I have received a copy of The Mouth Matters LLC/Amy Ford's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

☐ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

☐ I understand The Mouth Matters LLC/Amy Ford cannot disclose my health information other than as specified in the notice.

☐ I understand that The Mouth Matters LLC/Amy Ford reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client

Please Note: It is your right to refuse to sign this Acknowledgement.

HIPAA Privacy Notice Acknowledgement

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s)

- An emergency prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgement.
- Other: _____

_____ _____

Staff Member Signature Date