Anne Reynolds, M.S., CCC-SLP

Pediatric Speech-Language Pathologist
Anne Reynolds, LLC
MD License Number: 01497

Phone: (301) 933-3061 **FAX: (301) 933-3062**

Dear ____ ,

This packet contains forms to be completed and returned by mail, e-mail or fax prior to your appointment. Please return all forms by mail, e-mail or fax one week prior to the evaluation or treatment date. If you fax or e-mail 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 (301) 933-3061.

Please return forms to:

Anne Reynolds, M.S., CCC-SLP
Communication Cornerstones
10605 Concord Street, Suite 102
Kensington, MD 20895

Sincerely,

Anne Reynolds, M.S., CCC-SLP

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

- ☐ Complete the packet.
- ☐ Mail, e-mail or fax the completed packet. If the packet is e-mailed or faxed, please bring original forms to evaluation/treatment date.
- ☐ Send other relevant reports.

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Acknowledgment and Assumption of Risk

I, ________________________________ (*print name*), acknowledge and agree to have my child (or the child under my care), ________________________________ (*print child's name*), receive speech therapy services from Anne Reynolds, M.S., CCC-SLP and/or any independent contractor at Anne Reynolds, 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 Anne Reynolds, M.S., CCC-SLP, or any of the independent contractors, harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belongings.

Signature

Print Name:________________________________ Date: ____________________

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Consent to Release Form

I, ______________________________(print name), give permission and consent to Anne Reynolds, LLC, Anne Reynolds, M.S., CCC-SLP, and their respective consultants and agents (hereinafter, collectively, the "Company") to discuss and speak with school officials, teachers, psychiatrists, medical doctors, occupational therapists, insurance representatives, and other professionals (collectively, "Third Party Professionals") regarding my child (or the child under my care) as may be needed in connection with the treatment and/or evaluation of such child 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 child. The undersigned further authorized the Company to release any and all information pertaining to the treatment and/or evaluation of the child to any Third Party Professional that may in any way be involved in the treatment and/or evaluation of the child.

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 HIPAA, 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 child.

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

AGREED AND ACCEPTED:

Signature ____________ Date

Print Name:______________________________

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Parental Consent Form

I, ______________________________ (*print name*), give my permission to Anne Reynolds, LLC, Anne Reynolds, M.S., CCC-SLP, and their consultants (hereinafter, collectively, the "Company") to observe my child (or the child under my care) ______________________ (*print name*), at __________________ School. I understand that during this observation, the Company may speak with the classroom teacher and other professionals at the school about my child.

Signature

Print Name:______________________________ Date: __________________

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Consent Form

NAME	TELEPHONE NUMBER	DATE	INITIAL

Signature ______________ Initial ______________ Date

I, ________________________________, give my permission to __________________________ at Anne Reynolds, LLC and Associates to speak with the above listened professionals regarding my child ______________________________.

Anne Reynolds, M.S., CCC-SLP

Pediatric Speech-Language Pathologist
Anne Reynolds, LLC
MD License Number: 01497

Current Fee Schedule and Payment Policy as of September 1st, 2018

The following is the current Fee Schedule and Payment Policy for services to be provided to your child by Anne Reynolds, M.S., CCC-SLP, Anne Reynolds, LLC and/or its consultants (the "Company"). Please understand that the Company reserves the right to change and/or modify the fees set forth below, but you will receive thirty (30) days advanced notice of any increase in such fees. All fees and costs shall be due and payable in accordance with the Agreement to Terms of Payment.

Fee Schedule

Evaluations	To be determined by length/content of the evaluation	Includes written report
Therapy (In office)	$150.00 (per hour)	Individual
Therapy (Out of office)	$160.00 (per hour)	
Consultation	$170.00 (per hour)	In/Out of office

*Evaluations include the following components: formal testing, scoring, interpretation, report writing, consultation with teacher or family.

Payment for Services

For your convenience, we accept Visa and MasterCard as well as debit from your checking or savings account. **We do not accept checks.** Credit Card and Debit charges will be processed on the first day of each month and itemized statements will be sent to you.

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:

Anne Reynolds, M.S., CCC-SLP
10605 Concord Street
Suite 102
Kensington, MD 20895

Cancellation and No-Show Policy

Our practice has a 24 hour cancellation policy. Appointments that are not cancelled are considered "no-show" and will be billed at the full rate. For all cancellations, please call or e-mail your therapist.

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

Anne Reynolds, M.S., CCC-SLP

Pediatric Speech-Language Pathologist

Office: (301) 933-3061

Fax: (301) 933-3062

Private Practice & Consultation

Credit Card/ Debit Transaction Processing Authorization Form

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

☐ Yes, I would like to have my checking account debited for services rendered each month.

Card Type	Number	Exp. Date	CID Code
☐ Visa			
☐ MasterCard			

Name on the card: ____________________

Billing Address: ____________________

____

____

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 Anne Reynolds, LLC and/or its duly authorized agent (the "Company") has the right from time to time 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 charged 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:

Cardholders Signature:____________________ Date:____________________

Print Name: ____________________

*All Credit Cards will be processed on the first day of each month.

**All Debits will be processed on the first day of each month.

I, ____________________ authorize Anne Reynolds, M.S., CCC-SLP to send paid invoices via electronic mail in PDF format to ____________________.

Signature:____________________ Date: ____________________

Anne Reynolds, M.S., CCC-SLP

Pediatric Speech-Language Pathologist
Anne Reynolds, LLC
MD License Number: 01497

Agreement to Terms of Payment

I, ____________________________________ (*print name*), acknowledge and accept full and complete responsibility for payment of all services rendered to my child or any child under my care by Anne Reynolds, LLC, Anne Reynolds, M.S., CCC-SLP, and/or its consultants. I acknowledge that I have received written explanation of the fee schedule, cancellation policy, and payment policy and I agree to all.

I understand that health insurance policies are an arrangement between my insurance company and myself, that all services rendered to my child or any child under my care 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 myself and Anne Reynolds, LLC and are not related to potential insurance coverage. I understand that while Anne Reynolds, LLC may assist me in completing forms to aid in collecting insurance benefits for services that are billable, ultimately it is my responsibility to complete and file such forms. I agree to the release by Anne Reynolds, LLC and/or its duly authorized agents of any information that is requested by my insurance company.

Date: ___________________

Signature of Parent/Legal Guardian

Printed Name of Parent/Guardian: ____________________________________

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GENERAL ACKNOWLEDGEMEMT OF FORMS

I do hereby acknowledge and agree that: (i) I have read all of the forms and documents provided to me in connection with the evaluation and treatment of my child (or the children under my care) by Anne Reynolds, LLC, Anne Reynolds, M.S., 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 own free volition and without any coercion from any third party.

Date:____________________

Signature of Parent/Guardian

Print Name: ___________________________ Witness:___________________________