Hudson Valley Speech & Swallowing Therapy PLLC

Patient Consent for Treatment

Recognizing the need for therapeutic care, I consent to all diagnostic and therapeutic treatment employed by the therapists of Hudson Valley Speech & Swallowing Therapy PLLC. I understand that the practice of any medical science including Speech-Language Pathology is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment.

I consent to have copies of my records released to insurance carriers, federal and state agencies, and other health care facilities as may be required for the processing of insurance claims and/or continued medical care. I acknowledge that all medical records will be kept confidential with the exception of the aforementioned circumstance unless I provide written consent for release to additional parties.

Fees: I acknowledge that I am responsible for knowing and understanding the coverage and limitations of my particular insurance including the need for prior authorizations as it pertains to outpatient Speech-Language and Dysphagia (swallowing) therapy. I acknowledge that I am solely responsible for the payment of any procedures performed which are not covered by my insurance carrier and agree to pay any uncovered procedures.

I have read the above or had it explained to me and I understand its contents.

	_____	_____
Patient Name	Patient Signature	Date
	_____	_____
Parent or Guardian	Witness	Date