Essence
Speech-Language Pathology Services

781.820.4610 Jgibbons025@gmail.com

I, _____, hereby authorize Jessica Gibbons of Essence Speech Pathology Services to evaluate and treat _____ for speech therapy.

_____ _____
Signature **Date**

I understand that the patient's protected health information may be used and disclosed to carry out treatment, payment, or healthcare operations. For a more complete description of the potential uses of disclosures of the protected health information, please refer to the Notification of Privacy Practices issued on the first day of treatment. If you have misplaced your copy, please feel free to contact the office by email at jgibbons025@gmail.com to request that we send one to you via email or US Mail. The Notice of Privacy Practice may change and you have the right to an updated copy. To receive a copy, please contact us. You have a right to review the Notice of Privacy Practices prior to signing this consent. If you have any questions, you may contact Jessica Gibbons at jgibbons025@gmail.com or 781.820.4610. Please note that you have the right to request that Essence Speech Pathology Services restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. It should be noted that the provider is not required to agree to requested restrictions; however, if the provider agrees to a requested restriction, the restriction is binding on the provider. You have a right to revoke the consent in writing, except to the extent that the provider has taken action in reliance on it.

_____ _____
Signature Date

I give consent to leave a message on my voicemail system regarding my care.

_____ _____
Signature Date

I give consent to communicate via e-mail regarding my care.

_____ _____
Signature Date

I authorize payment of medical benefits and/or government benefits to Essence Speech Pathology Services.

_____ _____
Electronic Signature Date