Oral Function SPECIALTIES

Connecting oral health and wellness through a lifetime

Commitment Agreement

I authorize the therapist to perform all recommended treatment mutually agreed upon by me. The success of therapy is dependent upon the following:

- Attendance at weekly therapy sessions
- Daily exercises, two or three times each day, with parental supervision if needed
- Keep a positive attitude

I agree to commit to the therapy process as outlined above.

Patient /parent signature: _____ Date: _____

HIPAA—Health Insurance Portability and Accountability Act

I have received a copy of the Notice of Privacy Practices in compliance with HIPAA guidelines.

Patient /parent signature: _____ Date: _____

Consent to Use of Name or Picture

I consent that my name and or picture of me/my child may be used by Oral Function Specialties for such purposes as research, writing and professional activities, and may be used, exhibited and published for educational and promotional purposes and includes any media currently in use or for future use.

Patient /parent signature: _____ Date: _____

Financial Agreement/Cancellation Policy

I agree to pay Oral Function Specialties $ 275/ evaluation; $ 85/ session Terms: monthly payments
I understand I will be responsible for payment one month ahead of time for the following full month of therapy. Payments will be expected on the 10th of the month for the next month of therapy appointments to be scheduled. Sessions are generally held weekly at a set appointment time. If appointments are broken by the patient, no refund will be given. In the case of appointments cancelled due to sudden illness, every effort will be made to reschedule the patient on an additional day within that week, however we cannot guarantee that appointment times will be available.

Patient /parent signature: _____ Date: _____

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Authorization for Release of Information

This authorization will authorize Oral Function Specialties to obtain and furnish pertinent information regarding the condition of the patient while under observation or treatment. This information may be obtained from and/or released to:

Dentist: _____ Phone: _____
Orthodontist: _____ Phone: _____
Physician: _____ Phone: _____
Insurance Company: _____

Patient /parent signature: _____ Date: _____