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 or biweekly therapy sessions
- Daily exercises, two or three times each day, with parental supervision if needed

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 until 2035.

Patient /parent signature: _____ Date: _____

Financial Agreement/Cancellation Policy

I agree to pay Oral Function Specialties $125/ consultation; $ 425/ evaluation; $ 200/ session
I understand I will be responsible for the evaluation payment before for the first appointment to hold my appointment time and date. I agree that if I no show or cancel the evaluation without 24 hours notice, an administrative fee of $175 will be assessed. For session appointments, payment is due at the time of service. I agree that if I no show or cancel an appointment without 24 hours notice, my credit card on file will be charged $75.

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Payment Authorization and Receipt: If paying by Venmo, Zelle, or credit card, you give us permission to charge your credit card or debit card as payment for your child's assessment, and you will receive an electronic receipt.

Patient /parent signature: _____ Date: _____

Authorization for Release/Sharing 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/EMail: _____
Orthodontist: _____ Phone/EMail: _____
Physician: _____ Phone/EMail: _____
Bodyworker: _____ Phone/EMail: _____
Therapist: _____ Phone/Email: _____
Other: _____ Phone/Email: _____

Patient /parent signature: _____ Date: _____