Vegas Voice Institute
CONSENT FOR TREATMENT AGREEMENT TIER 3

Patient Information			
Name:		SSN#:	DOB:
Age: ______________ ☐ Male ☐ Female			
Address:			
City:	State:		Zip Code:
Home Phone:	Office Phone:		Cell Phone:
Employer:		Occupation:	
Emergency Contact:		Phone:	
Who were you referred by?			
E-mail address:			
Would you prefer to get reminder calls by telephone or email: ☐ Telephone ☐ Email			

ASSIGNMENT OF BENEFITS

A late fee of $20 per month will be added to all accounts 30 days past due. In the event this account is given to an attorney, or an agency for collection, the patient/responsible party agrees to pay reasonable attorney fees, legal fees, and lawful collection costs in addition to all sums due thereafter.

Cancellation and no show policy: I understand that I must give at least **24-hour notice** of the cancellation of a speech therapy session, which can be made by contacting Vegas Voice Institute. I also understand if at anytime I "no call, no show" for a scheduled appointment or do not give a 24 hour notice for a cancelled therapy session, I will be charged a $**50 fee for the 1st occurrence. The 2nd occurrence you will be charged $125.00.** This fee must be paid in full before another scheduled appointment can be made. If participant in therapy incurs more than 1 no show or 2 cancellations, participant will be subject to discharge from the therapist's caseload as determined by the therapist.

Responsible Party:____ Date:_________________

I acknowledge by my signature that I have read the above and agree to the stated terms. I also acknowledge that I received a copy of the Notice of Privacy Practices.

Updated: 8/12/2010