

# Vegas Voice Institute

## CONSENT FOR TREATMENT AGREEMENT TIER 3

Patient Information		
Name:	SSN#:	DOB:
Age: _____ <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Telephone <input type="checkbox"/> Email		

<b>ASSIGNMENT OF BENEFITS</b>
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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 2<sup>nd</sup> 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.