To All New Clients and Families:

We are happy to provide therapy services to your child at Providence Academy and want to help them in every way we can. Our private practice has been in existence since 1981 and has a long history of providing high quality services and reliability to our clients.

Before we are able to treat your child, completion of the following paperwork is required. Please let us know if you need assistance or have any questions.

We‘re excited to be part of your child’s team!

Thank you for choosing Sidekick Therapy Partners!

Sara Pack
Operations Support Specialist
865-693-5622
spack@mysidekicktherapy.com

Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice explains how your medical information may be used and disclosed and how you can gain access to this information. **Please review it carefully.** We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. If you have any questions, you can call us at (865) 693-5622.

Your Rights

You have the right to:

- Obtain a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Obtain a list of those with whom we have shared your information
- Obtain a copy of this notice
- Choose someone to act for you or as your representative
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have a choice in the way we use and share information as we inform family, caregivers, and others interested in your care about your condition.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Bill for your services
- Help with public health and safety issues
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions in compliance with the law
- Operate our healthcare organization. This includes (if applicable to you) obtaining permission from your child's insurance company to provide in-school IEP services and coordinating and managing those services with school system staff.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and our responsibilities to help you.

Inspect or obtain an electronic or paper copy of your medical record.

- You can ask to see or obtain an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, typically within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will explain why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home phone, office phone or by email) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Obtain a list of those with whom we have shared information.

- You can ask for an accounting of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. A request for such accounting will be responded to within 60 days, which may be a request on our part for an additional 30 days to respond and the reasons for such a delay.
- We will include all the disclosures except for those about treatment, payment, and health care operations, for such uses as separately and expressly authorized by you, and certain other disclosures, such as any you asked us to make. We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another within 12 months.

Obtain a copy of this privacy notice.

- You can request a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.
You can file a complaint if you feel we have violated your rights. Call us at 865-693-5622 and ask to speak to Krissie Self, email kself@mysidekicktherapy.com or write to us at the address listed at the bottom of page 2 of this notice.
You can file a complaint with the Secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html.
We will not retaliate against you for filing a complaint with us or the Secretary of U.S. Department of Health and Human Services.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a preference for how we share your information in the situations described below, let us know. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us how to share information with those involved in your care.

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways:

- **Treat you.** We can use your health information and share it with other professionals who are treating you or who have referred you to us for services. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services.** We can use and share your health information to bill and obtain payment from health plans or other entities. *Example: We provide information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?
We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html**.**

Comply with the law.
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services to demonstrate compliance with federal privacy law.

Address workers' compensation, law enforcement, and other government requests.
We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.

Respond to lawsuits and legal actions.
We can share health information about you in response to a legal order from a court or administrative order, or in response to a subpoena.
Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html.

Changes to the Terms of this Notice
We can change the terms of this notice at any time, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Other Instructions for Notice

- This notice is effective June 1, 2021. It replaces our earlier notice.
- Krissie Self is our company's privacy contact. You may contact her by phone at (865) 693-5622, email at kself@mysidekicktherapy.com, or write to the address at the bottom of the page.

Your child's public school system may have approved an Individualized Education Program (IEP) for your child that includes speech pathology services. If your child receives such IEP-related services, we will use or disclose your child's information and patient file to school system staff, including the school's Special Education Department. We provide this information to: (i) help the school system manage the services we provide to children with IEPs, and (ii) inform the school system and Special Education Department staff of your child's evaluation results, therapy, progress in therapy, and progress toward meeting your child's IEP goals.

Sidekick THERAPY PARTNERS
mySidekickTherapy.com

310 Corporate Drive, Suite 101
Knoxville, TN 37923
(865) 693-5622

Consent to Share with School Staff

Client Name: _____

Date of Birth: _____

Your child will receive/is receiving teletherapy services provided by Sidekick Therapy Partners. Sidekick Therapy Partners will be serving your child at their school for outpatient services. At times, it will be beneficial to share speech and language goal progress and carryover activities with your child's teacher or other school staff.

To comply with HIPAA regulations and to have those conversations as needed, you will need to grant permission and sign below. This document will be in effect for the duration of services unless otherwise specified in writing by the parent/legal guardian.

Please check the box below and return this form to the school or take a photo and email it to us at bkriehn@mysidekicktherapy.com

☐ **I grant permission** for the speech therapist to share information about my child's progress and goals with their teacher, when appropriate, and to access school records that include medical information.

☐ I do not grant permission for the speech therapist to communicate progress and goals with my child's teacher when appropriate.

Client/Parent/Guardian Name (print): _____

Signature: _____ **Date:** _____

If you have any questions, please contact us at 865-693-5622

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HIPAA CONSENT FORM-OFFICE/COMMUNITY

Authorization for Release of Health Information

I have received a copy of Deborah L. Curlee Communication Consultants, dba Sidekick Therapy Partners ("Sidekick") Notice of Privacy Practices.

I authorize Sidekick to use and disclose my child's complete patient file, including personal health information related to therapy and testing to: (i) my child's insurance company (TennCare or otherwise), (ii) my child's physician and other healthcare providers, and (iii) as provided in Sidekick's Notice of Privacy Practices. This authorization is voluntary and once that information is disclosed, it may be re-disclosed and no longer be protected by federal privacy regulations if the recipient is not a healthcare provider. However, it is my understanding that Sidekick does not disclose this information except to my health insurance company, other healthcare providers, or as provided in its Notice.

The purpose of Sidekick's use and disclosure of this information is to facilitate Sidekick providing therapy services to my child, obtain health insurance company authorization and payment for services, and coordinate or manage my child's care with other healthcare providers.

This authorization will be in force and effect for as long as my child is receiving services from Sidekick and, after Sidekick services end, for as long as the law or insurance company requires Sidekick to preserve my child's records. I have the right to revoke this authorization at any time by writing to Sidekick at the address listed below. Treatment, enrollment, eligibility, or benefits will not be conditioned on whether I sign this authorization.

I also consent to the use and disclosure of my child's complete patient file, including personal health information, for the purposes noted in Sidekick's Notice of Privacy Practices or as otherwise authorized by law. I also consent to Sidekick evaluating and providing therapy to my child and taking actions to establish and maintain my child's TennCare or other eligibility for services, obtain payments from TennCare or other insurance companies, and share the results of Sidekick's testing and therapy with my child's insurance company and doctor.

I, _____ (PRINT CAREGIVER NAME), do hereby consent and acknowledge my agreement to the terms set forth in the Sidekick NOTICE OF PRIVACY PRACTICES (HIPAA Information brochure) and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Child's Name (PRINT) Date of Birth

_____ _____

Caregiver Phone Number Caregiver email address

_____ _____

Caregiver Signature Date

Sidekick THERAPY PARTNERS
mySidekickTherapy.com

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Knoxville, TN 37923
(865) 693-5622

FINANCIAL AGREEMENT

Child's Name: _____ Date of Birth: _____

Address: _____

Parent/Guardian: _____ Phone: _____

Physician: _____ Phone: _____

Insurance: _____ ID#: _____

All therapy fees including co-pays, co-insurance and *Private Pay payments are due at time of service.

***Private Pay**: Patients without insurance coverage or are covered by an insurance plan our office does not participate in.

Forms of Payment: We accept American Express, Discover, Mastercard Visa and personal checks. We DO NOT accept cash payments.

Verification of Benefits: As a courtesy, Sidekick will contact your insurance provider to obtain benefit information including deductible, co-pay, co-insurance amounts, visit limits and prior authorization requirements. (Prior Authorization may be required by your carrier after an evaluation has been completed.)

This information is obtained as a good-faith effort and is never a guarantee for payment. The insurance company makes the final decision regarding your eligibility and benefits. If your provider determines any services are "not covered" or are denied, you will be responsible for any and all outstanding charges. **It is the patient's responsibility to know the terms of their insurance plan.**

Change in Carrier or Benefits: If you have a change of insurance provider, or a change of health benefits please notify our office immediately. Your account and billing information will be updated, and a new verification of benefits will be completed.

By signing below, I / We agree to pay for all services rendered. Sidekick may bill the insurance carrier for services provided and may extend payment for ninety (90) days to allow sufficient time for the insurance company to pay. However, if payment is not received within 90 days of services being rendered, we agree to pay Sidekick immediately.

I have read the above policies, understand them, and agree with them.

Signature of Client or Caregiver: _____ Date: _____

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(865) 693-5622

ATTENDANCE POLICY

A healthcare relationship is built on mutual trust and respect. In order to meet the needs of our patients and provide effective treatment regular attendance is necessary. We strive to be on time for scheduled appointments, and we appreciate your being respectful of the needs of other clients and your child's therapist.

Emergency Cancellation: We understand emergencies arise due to illness, illness of family member, death in the family, etc. We ask that you contact our office as soon as possible to report an emergency.

Non-Emergency Cancellation: ALL non-emergency cancellations must be within at least **24 hours** prior to your scheduled appointment. Appointments are in demand; your early cancellation allows us time to reschedule with another family in need of an appointment.

How to Cancel an Appointment: Call the clinic at 865-693-5622 and speak to the receptionist or you may leave a detailed message on our voicemail which is available 24 hours a day.

No Show: A "no-show" is a missed scheduled appointment without notification of cancellation. It also includes being more than 15 minutes late for an appointment.

Make Up Sessions: Contact the clinic to discuss availability for a make-up session with your therapist or another therapist who is available.

Frequent Cancellations or No Shows: If the attendance rate falls below **75%** or a client with late cancellations more than **25%** of the time during any month will have the number of weekly appointments reduced (usually from 2 appointments to 1). If they are able to make these appointments, we may resume more frequent therapy sessions. However, if the client continues to miss these reduced appointments, they may be discharged.

Sidekick Therapy Partners reserves the right to suspend services at their discretion.

I agree to all of the terms of this policy and understand that frequent cancellations and no shows may result in reduced therapy sessions or discharge from this practice.

_____ _____

Signature Date

_____ _____

Printed Name of Caregiver Child's Name

Sidekick THERAPY PARTNERS
mySidekickTherapy.com

310 Corporate Drive, Suite 101
Knoxville, TN 37923
(865) 693-5622

CONSENT FORMS

Child's Name: (please print) _____

Caregiver Name: (please print) _____

Photograph/Video for Social Media & Marketing

I consent and authorize Sidekick Therapy Partners ("Sidekick") to use my likeness in any photograph, video, or other digital media in any and all of its publications, including print or web-based publications and social media.

I hereby grant permission to Sidekick Therapy Partners ("Sidekick") and its employees the irrevocable and unrestricted right to reproduce the photographs and/or video images taken of me, or members of my family, for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium, including print, web-based publications, and social media. I irrevocably authorize Sidekick to copy, edit, enhance, crop, or otherwise alter any photo for use in their publications. I also waive any rights for approval or inspection of any photos. I understand that I am under no obligation to consent.

I understand that all photos and video are property of Sidekick. I hereby release Sidekick and its legal representatives for all claims and liability relating to said images or video. I waive my right to any compensation.

Note: Last names or addresses will never be included in print, web, or on social media.

Signature:_____ Date: _____

Audio/Video for Treatment Planning Only

I hereby grant permission to Sidekick, the rights to record my child's therapy session (in person or via teletherapy) and of the likeness and sound of my/my child's voice as recorded on audio or video tape. **I understand that this audio and/or video is to be used for the purposes of evaluating and treating the client and the accompanying impairment and is used to assist Sidekick's Therapists in determining a diagnosis and treatment plan. I understand that this material may also be used to train other Sidekick therapists within the organization but will not be distributed.** The audio/video for the client will be stored securely in the client's file within our organization. I waive any right to royalties or other compensation arising or related to the use of the recording. There is no time limit on the validity of this release. This release applies only to audio or video recordings collected as part of the evaluation and treatment sessions performed for the client.

Signature:_____ Date: _____

CONSENT FORMS

Child's Name: (please print) _____

Caregiver Name: (please print) _____

College and University Partnerships

Sidekick Therapy Partners appreciates the need to train professionals in speech therapy. We occasionally partner with local colleges and universities whose students observe and take part in our therapy sessions under 100% supervision of our certified therapists. We will inform you if there will be a college or university student involved in your child's therapy session and you always have the option to switch to another therapist if you would like. If you have any concerns about this, please talk to your child's therapist.

My signature below verifies I have read this statement.

Signature:_____ Date: _____

Open Gym Consent

Sidekick Therapy Partners has an open therapy gym where our therapists may use larger equipment or spaces to target your child's individualized goals. Your child may be receiving therapy in the open gym area where other children are engaging in therapy activities. Your child may possibly interact with other children and therapists (if your therapist thinks it would be beneficial to your child's treatment). Additionally, other parents/children in the gym may overhear your therapist talking to you and your child during the therapy session, which may include your child's name and progress.

If you have any concerns about this, please talk to your child's therapist.

My signature below verifies I have read this statement.

Signature:_____ Date: _____

Please fill out the following to the best of your ability and with as much detail as possible. Feel free to attach extra paperwork to answer questions. "Not Applicable" is given as an option for when a skill is not appropriate at your child's age. For example, a 9-month-old child would not be expected to engage in imaginative play. This will help your child's therapist complete a well-rounded care plan for him/her.

Child's Name: _____ **Date of Birth:** _____

What do you see as your child's biggest difficulty at home/in the community? What would you like to gain from this evaluation? _____

What diagnoses, if any, have your child received from a doctor? _____

Birth and Medical History

Did Mom take any medication while pregnant? ☐ **Yes** ☐ **No** If ***YES***, please list: _____

Were there any complications during the pregnancy for? ☐ **Mom** ☐ **Baby**

Was Mom referred to maternal fetal medicine? ☐ **Yes** ☐ **No**

If you answered ***YES*** to either of these questions, please describe: _____

Length of Pregnancy: _____ Birth Weight: _____

Check type of delivery: ☐ **Vaginal** ☐ **Induction** ☐ **Planned Cesarean** ☐ **Emergency Cesarean**

Were there any complications during labor/delivery (ex: mother high BP, baby low/high HR, low oxygen, etc.)? ☐ **Yes** ☐ **No**
If YES, please describe: _____

Were there any complications immediately after delivery? ☐ **Yes** ☐ **No**
If YES, please list here: _____

Was your child in the NICU? ☐ **Yes** ☐ **No**
If YES, please describe why and how long: _____

Has your child had surgery? ☐ **Yes** ☐ **No**
If YES, please write type and dates here: _____

Has your child had his/her vision tested? ☐ **Yes** ☐ **No**
If YES, what were you told? _____

Has your child had his/her hearing tested? ☐ **Yes** ☐ **No**
If YES, what were you told? _____

Child's Name: (please print) _____

Caregiver Name: (please print) _____

Has your child had any of the following? **Check the ones that apply:**

☐ Adenoidectomy
☐ Chicken Pox
☐ Ear Tubes
☐ Feeding Tube
☐ Seizures
☐ Strep Throat
☐ Other: _____
☐ Anxiety
☐ Constant Colds
☐ Encephalitis
☐ Head Injury
☐ Sinus Infection
☐ Tonsillectomy
☐ Breathing Difficulties
☐ Ear Infection
☐ Feeding Difficulties
☐ High Fevers
☐ Sleeping Difficulties
☐ Vision Problems

Developmental History:

Was your child on time for meeting developmental milestones (walking, talking, sitting up, etc)? ☐ **Yes** ☐ **No**

If ***No***, please outline which he/she was LATE in meeting. _____

_____

Does he/she take medication? ☐ **Yes** ☐ **No** Please specify the type of medication and dosage: _____

_____

Does he/she have allergies? ☐ **Yes** ☐ **No**

If ***YES***, please place a check beside those that apply and **list specifics** next to the category:

☐ Food
☐ Seasonal
☐ Animals
☐ Latex
☐ Medicine
☐ Other : _____

Are any specialists (i.e. GI, Dermatologist, Cardiologist, etc) treating your child in addition to his/her pediatrician? ☐ **Yes** ☐ **No**

If YES, please write name/specialty here: _____

Has your child ever received therapy of any kind (ABA, OT, PT, Speech, psychological, etc.). If YES, please outline below:

Dates	**Type**	**Provider**

Family Medical History

Have any family members received any of the following diagnoses?
Check the ones that apply and note next to it the relation of the family member to your child.

☐ Autism
☐ ADD/ADHD
☐ Anxiety
☐ Bipolar
☐ Other: _____
☐ Depression
☐ Dyslexia
☐ Epilepsy/Seizure Disorder
☐ Hearing Problems
☐ Learning Disability
☐ OCD
☐ Other Mental Health

Child's Name: (please print) _____

Caregiver Name: (please print) _____

Social History

Please list the names of **ALL persons living in the home** as well as the relation to the child (grandparent, sibling, parent, step-parent, foster parent, adoptive parent etc.) and gender. Please list the ages of SIBLINGs.

_____

_____

Is there a language other than English spoken in the home? ☐ **Yes** ☐ **No** If yes, which one? _____

Does your child speak the language? ☐ **Yes** ☐ **No**
Does the child understand the language? ☐ **Yes** ☐ **No**
Who speaks the language? _____

Which language does the child prefer to speak at home? _____

What type of school does your child attend?

☐ Public ☐Private ☐Homeschooled ☐Not Applicable ☐Other:_____

Name of School (curriculum if home schooled): _____

Grade:_____ Classroom Type: ☐ Gen Ed ☐ CDC ☐ Other:_____Accommodations: ☐ IEP ☐ 504 ☐ None

Please list any concerns his/her teacher has shared with you: _____

_____

Check which school subjects are his/her strengths and/or favorites:

☐ Math ☐ Science ☐ English (Spelling/Reading) ☐ History

☐ Art ☐ P.E. ☐ Computer ☐ Foreign Language ☐ Other: _____

Describe Your Child

What is your child's favorite activity? _____
What is your child's favorite show/movie? _____
What helps him/her calm down? _____
What type of play does your child engage in?

☐ Independent play ☐ Parallel play ☐ Play with same-aged peers ☐ Imaginative play

Check the characteristics that apply:

☐ Attentive	☐ Distractible	☐Inquisitive
☐ Active	☐ Destructive	☐ Inappropriate Behavior
☐ Aggressive	☐ Emotional	☐ Kind
☐ Calm	☐ Friendly	☐ Loving
☐ Caring	☐ Funny	☐ Smart
☐ Cooperative	☐ Happy	☐Self-Injurious
☐ Easily Frustrated	☐ Impulsive	☐ Stubborn
☐ Separation Anxiety	☐ Anxious	☐ Withdrawn
☐ Shy	☐ Poor Eye Contact	☐ Adventurous

Please feel free to write out anything else your child's therapist may need to know.

TELETHERAPY CONSENT FORM

I, _____(PRINT GUARDIAN NAME), do hereby consent to participate in teleservices with **Sidekick Therapy Partners** during the period of an office closure or periods when in-person services are unavailable. I understand that this consent shall remain in effect from this time forward until I elect to discontinue these teleservices in writing.

I understand that teleservice will be used to deliver therapy services via technology assisted media or other electronic means between a Speech Language Pathologist or other professional practitioner, as agreed, and a client who are in two different locations. I understand the following with respect to teleservices:

1) I understand that I have the right to withdraw consent at any time without affecting my child's right to future services, or program benefits to which my child would otherwise be entitled.
2) I understand that there are risks and consequences associated with teleservices, including but not limited to, disruption of transmission by technology failures, interruption and/or unintended breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my child's protected health information (PHI) also apply to teleservices unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others).
5) I understand that if my child is experiencing a mental health crisis that cannot be resolved remotely, it may be determined that teleservices are not appropriate, and a higher level of care is required.
6) I understand that the Health Insurance Portability and Accountability Act of 1996 prohibits any further disclosure of this information without my specific written consent, or as otherwise permitted by such regulations. I understand that I have the right not to consent to disclosure of this information. I understand I have the right to revoke this authorization at any time. I understand that this consent shall remain in effect until revoked by me, in writing, and delivered to Sidekick Therapy Partners, but that any such revocation shall not affect disclosures previously made by Sidekick Therapy Partners prior to the receipt of any such written revocation.

Recommendations for a successful teleservices session:

- ✓ A laptop or personal computer with a camera and microphone and internet access is ideal; however, a smart phone with a camera may also work.
- ✓ A "quiet area" that is not accessible by other children or pets during the session.
- ✓ An adult who can assist your child with connecting, troubleshooting any connection issues, remaining online during the session, and navigating the session activities.

I understand that during a teleservice session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please contact our office at 865-693-5622 to discuss as we may have to reschedule.

_____ _____

Child's Name [print] Birthdate

_____ _____

Guardian Signature Date

Consent to Share with AAC company

Client Name:
Date of Birth:

Thank you for being a patient at Sidekick Therapy Partners! In the event that we would like to discuss Augmentative & Alternative Communication (AAC) options for your child, these written and verbal conversations involve the sharing of relevant private health information with an outside AAC company.

To comply with HIPAA regulations and to have those written and verbal conversations as needed, you will need to grant permission and sign below. This document will be in effect for the duration of services unless otherwise specified in writing by the parent/legal guardian.

Please check one of the boxes below and return this form to your child's speech-language pathologist or take a photo and email it to us at bkriehn@mysidekicktherapy.com

☐ **I grant permission** for the employees at Sidekick Therapy Partners to communicate with AAC companies (including sharing private health information as needed) and to complete medical records within the AAC company's funding portal when requested.

☐ I do not grant permission for the speech therapist to communicate with the listed AAC company.

Client/Parent/Guardian Name (print): _____

Signature: _____ **Date:** _____

If you have any questions, please contact us at 865-693-5622.

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