HIGH FIVE
SPEECH THERAPY

Emily Goudreault, M.A., CCC-SLP
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SUMMER BUDDIES & LUNCH BUDDIES: POLICIES

Payment Options:

Option 1 (Default Option): Pay in full upon registering. Payment can be made through cash, check, debit/credit card, FSA/HSA cards (if allowed on your plan), Venmo, PayPal.

Option 2 (Upon Request Only): 25% Deposit upon registering, remaining monthly balance due on 1st day of month.

1. **Deposit Payment Options:** cash, check, debit/credit card, FSA/HSA cards (if allowed on your plan), Venmo, PayPal.

2. **Remaining Balance Payment Options:** a debit/credit card or FSA/HSA card (if allowed on your plan) must be submitted upon registration and kept on file. This card will be run on the 1st of the month for your remaining balance.

   Example: Your child is attending Summer Buddies in June, July and August.
   - A 25% deposit for ALL months is required when you register.
   - The remaining 75% due for June's class is due June 1 (your card on file will be automatically charged).
   - The remaining 75% due for July's class is due July 1 (your card on file will be automatically charged).
   - The remaining 75% due for August's class is due August 1 (your card on file will be automatically charged).

Option 3: If you are interested in Summer Buddies and neither of these options are financially feasible for you, please contact Emily to discuss other options. We will work with you!

**Note: if your child is not currently receiving therapy services at High 5 Speech Therapy, a free screening with Miss Emily may be required prior to the Summer Buddies or Lunch Buddies class to ensure this group is the right fit for your child. After your registration has been submitted, you*

Refund Policy:

- Group cancellations: A full refund will be issued if the group is cancelled. In the event that a single class is canceled for any reason, you will be issued a prorated refund for the cost of the single group.
- Family cancellations 3 or more weeks (21+ days) before start date: a refund (minus a 25% deposit) will be issued for Summer Buddies if notice of cancellation is received 3 or more weeks prior to the start date.
- Family cancellations less than 3 weeks before start date (20 calendar days or less before start date): no refunds will be given and you are still responsible for the full cost of the group. All payments will be forfeited. If you have agreed to a payment plan, your remaining balance will still be deducted from the card we have on file for you on the 1st of the month.
- No refunds are given for missed sessions.
- Refunds will be made by the original payment method or check.

*Initials:*_____ I understand the refund policy.

No Guarantee of Results

*Initials:*_____ The success of all therapies and services are dependent on many variables including an individual's physical, environmental and developmental history/makeup, as well as his or her motivation and commitment. Individual clients will respond uniquely to our services. I make no claims as to the anticipated results of treatment.

I have read the above information and agree to consent to services. I agree that the outcome of my child's treatment is largely dependent on my, my family's and my child's effort. I indemnify and hold harmless High 5 Speech Therapy LLC, The Village and/or Emily Goudreault from any and all claims arising directly or indirectly from the services rendered under this agreement. Such indemnification shall include reasonable attorney fees and costs.

I understand the terms for receiving services. A copy of this disclosure information is available if requested.

I, _____, give permission to Emily Goudreault and/or High 5
Printed Name of Client's Parent/Guardian

Speech Therapy LLC to render services to _____.
Name of Client

I understand and agree to the outlined policies and have been offered a copy of these policies for my records.

_____
Signature of Client's Parent/Guardian *Date*

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SUMMER BUDDIES THERAPY GROUP: PAYMENT PLAN AGREEMENT

Payment Plan Option:

25% Deposit upon registering, remaining monthly balance due on 1st day of month.

- **Deposit Payment Options:** cash, check, debit/credit card, FSA/HSA cards (if allowed on your plan), Venmo, PayPal.

- **Remaining Balance Payment Options:** a debit/credit card or FSA/HSA card (if allowed on your plan) must be submitted upon registration and kept on file. This card will be run on the 1st of the month for your remaining balance.

  Example: Your child is attending Summer Buddies in June, July and August.
  - A 25% deposit for ALL months is required when you register.
  - The remaining 75% due for June's class is due June 1 (your card on file will be automatically charged).
  - The remaining 75% due for July's class is due July 1 (your card on file will be automatically charged).
  - The remaining 75% due for August's class is due August 1 (your card on file will be automatically charged).

Refund Policy:

- Group cancellations: A full refund will be issued if the group is cancelled. In the event that a single class is canceled, you will be issued a prorated refund for the cost of the single group.
- Family cancellations 3 or more weeks before start date: a refund (minus a 25% deposit) will be issued for Summer Buddies if notice of cancellation is received 3 or more weeks prior to the start date.
- Family cancellations less than 3 weeks before start date: no refunds will be given.
- No refunds are given for missed sessions.
- Refunds will be made by the original payment method or check.

I have read the above information and agree to the terms of the payment plan. I agree that my deposit will be forfeited should I cancel my child's registration in Summer Buddies with less than 3 weeks notice prior to the first class date of the month.

I, _____, give permission to Emily Goudreault and/or High 5
Printed Name of Client's Parent/Guardian

Speech Therapy LLC to hold a credit card on file and charge it for the remaining balance of that month's Summer Buddies Group on the 1st of that month. I understand and agree to the outlined refund and payment policies and have been offered a copy of these policies for my records.

_____

Signature of Client's Parent/Guardian *Date*

HIGH FIVE
SPEECH THERAPY
PEDIATRIC SPEECH + LANGUAGE + FEEDING THERAPY

Emily Goudreault, M.A., CCC-SLP
Speech-Language Pathologist • Owner

www.high5speechtherapy.com
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cell: 970.988.6718 • fax: 616.327.6366

NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully. This notice is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPPA). This notice describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment, and healthcare operations and for other purposes that are permitted or required by law. PHI includes any of your written or oral health information including demographic data that can be used to identify you. This is PHI that is created or received by High 5 Speech Therapy LLC and/or its agent.

Understanding Your Health Information
Each time you receive health related services a record is made of the treatment. Typically, this record contains your diagnosis and treatment notes. This information, often referred to as a health, treatment or medical record, serves as a:

- Basis for planning your care
- Means of communicating among the health professionals, e.g. therapists or physician who contribute to your care
- Legal document describing the care you received and means by which you or a third-party payer can verify that services billed were actually provided

Your Health Information Rights
Although your health record is the physical property of High 5 Speech Therapy LLC, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosure of your information as provided by 45 CFR 164.522
- Receive confidential communications of protected health information as provided by 45 CRF 164.522
- Inspect and copy your health record as provided for in 45 CFR 164.522
- Request to amend your health record as provided in 45 CRF 164.522
- Obtain an accounting of disclosure of your health information as provided in 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- Obtain a paper copy of the notice from High 5 Speech Therapy LLC upon request

The right to make a request does not guarantee it will be granted, the request may be denied based on certain situations; including, emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, for example. All requests must be made in writing.

High 5 Speech Therapy LLC Responsibilities
Maintain the privacy of your protected health information (PHI)
Abide by the terms of this notice
Notify you if I am unable to agree to a requested restriction

I will not use or disclose your health information without your authorization, except as described in this notice:

I will use your health information for <u>treatment and/or evaluation</u>.
For example, information obtained by a health-related services provider, e.g. primary care physician, physical therapist, audiologist, occupational therapist, speech/language pathologist, and/or psychologist, will be recorded in your record and used to determine the best plan of care for you.

I will use your Protected Health Information for <u>payment</u>. I may use and give your health information to electronically bill third party payers and collect payment for treatment services provided to you by a contracted agent or us.

By Signing below I acknowledge that I have reviewed the HIPPA Guidelines and have been offered a copy for my records.

_____
Printed Name of Client

_____
Printed Name of Client's Parent/Guardian

_____
Signature of Client's Parent/Guardian Date

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WAIVER AND RELEASE OF LIABILITY

High 5 Speech Therapy LLC and/or Emily Goudreault is not responsible for any injury (or loss of property) to any person while receiving any type of services from High 5 Speech Therapy LLC and/or Emily Goudreault, on/in any location, for any reason whatsoever, including ordinary negligence, on the part of High 5 Speech Therapy LLC and/or Emily Goudreault, or its employees, contractors, volunteers, agents, students and/or clients.

1. I, _____, in consideration of my or my child's participation in
Printed Name of Client or Client's Parent/Guardian

one or more of the programs provided by High 5 Speech Therapy LLC and/or Emily Goudreault hereby release, indemnify and covenant not to sue High 5 Speech Therapy LLC and/or Emily Goudreault, or its employees, contractors, volunteers, agents, students and/or clients from any and all present and future claims resulting from ordinary negligence, on the part of High 5 Speech Therapy LLC and/or Emily Goudreault, or others associated with High 5 Speech Therapy LLC and/or Emily Goudreault, as listed above, for property damage, personal injury or wrongful death, arising as a result of my or my child's engaging in or receiving instruction in therapy or any other activity or activities incidental thereto, whenever, wherever, or however the same may occur. On behalf of myself or my child, I hereby voluntarily waive any and all claims resulting from ordinary negligence, including but not limited to gross negligence, both present and future, that may be made by me, my family, estate, heirs or assigns on behalf of myself or my said child.

2. I further agree to indemnify and hold harmless High 5 Speech Therapy LLC and/or Emily Goudreault, and its employees, contractors, volunteers, agents, students and/or clients for any and all claims arising as a result of my or my child's engaging in or receiving instruction in High 5 Speech Therapy LLC and/or Emily Goudreault activities, or any activities incidental thereto, whenever, wherever or however the same may occur.

3. I understand that this waiver is intended to be as broad and as inclusive as permitted by the laws of the State of Michigan and agree that if any portion is held invalid, the remainder of the waiver will continue in full force and effect.

I affirm that I am _____, and am freely signing this agreement.
Printed Name of Client or Client's Parent/Guardian

I have read this agreement and fully understand that by signing this agreement I am giving up, on behalf of

_____, legal rights and/or remedies which may be available to
Printed Name of Client

me or my child for the ordinary negligence of High 5 Speech Therapy LLC and/or Emily Goudreault or any person associated with High 5 Speech Therapy LLC and/or Emily Goudreault.

I have read, understand and agree to the liability disclaimer and have been offered a copy of these policies for my records.

_____
Signature of Client or Client's Parent/Guardian Date