***SERVICE CONTRACT***

I have read **SPEEC POLICIES & PROCEDURES FORM** and agree to abide by it. I recognize that evaluation of my child can bring up issues that are difficult to discuss and which may cause me discomfort to examine. Knowing this, I consent to services with SPEEC, LLC.

You further acknowledge that the services provided to you by the SPEEC, LLC was conditioned on you providing this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature) (Date)

***Confidentiality***

**FOR FURTHER INFORMATION REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR EVALUATOR IN CONJUNCTION WITH THIS CLIENT INFORMATION AND CONSENT DOCUMENT**. By signing this information and consent form below you acknowledge receipt of a copy of the Notice of Privacy Practices. If you have any questions regarding confidentiality, you should bring them to the attention of the evaluator when you and the evaluator discuss this matter further. By signing this information and consent form below, you are giving your consent to the SPEEC, LLC to share confidential information with all persons mandated or permitted by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned evaluator for any departure from your right of confidentiality that may result.

You acknowledge that you have the right to revoke this authorization in writing at any time to the extent SPEEC, LLC has not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned evaluator that you have received and reviewed.

You acknowledge that you have been advised by the evaluator of the potential of the re-disclosure of your protected health information by the authorized recipients and that it may not be protected from unauthorized disclosures as required by the Federal Privacy Rule.

On behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, my minor child or person entrusted to me for guardianship, I agree to the above policies and give permission for SPEEC, LLC to provide services for my child.

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CHILD'S NAME DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME (RELATIONSHIP) SIGNATURE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME (RELATIONSHIP) SIGNATURE DATE