Wellington-Alexander
CENTER
DYSLEXIA ASSESSMENT & INTERVENTION

9821 East Bell Road • Scottsdale, AZ 85260 • phone: 480-629-4461 • fax: 480-629-5898 • www.wellingtonalexander.com

INFORMED CONSENT FOR EVALUATION AND/OR TREATMENT

PATIENT NAME: _____

I_____hereby consent to an evaluation and/or treatment of myself or my child, as indicated below, rendered by The Wellington-Alexander Center. I agree that should I present myself or my child for evaluation and/or treatment, that I have legal authority to do so. I understand that it is my responsibility to maintain scheduled appointments, provide payment for services rendered, and provide an accurate and complete account of current and past assessments, treatment, symptoms and concerns. Please check all that apply.

___ Speech/Language Evaluation
___ Speech/Language Treatment
___ Speech/Language Mini Assessment
___ Occupational Therapy Evaluation
___ Occupational Therapy

Confidentiality Disclosure:

I understand that the confidential nature of my records *may not be protected* under the following circumstances:

Suspicion or evidence of child abuse or neglect; Immediate danger to myself or others; Need for hospitalization; In the even that it becomes necessary to submit my charges to a collection agency for non-payment; Legal cases in which I am a plaintiff seeking medical or psychological damages; Legal cases in which I use my psychological status as a defense or mitigating circumstance; and cases involving health professionals who may be impaired or violating licensing statutes or rules.

I authorize release of only necessary information to other providers employed by The Wellington-Alexander Center for the purpose of assisting in the provision of appropriate diagnosis, treatment and care, and/or purpose of consultation and supervision.

Release of Information to Insurance

I understand that The Wellington-Alexander Center does not file insurance claims. Should I file an insurance claim for my child or myself, I understand that the insurance companies may request my medical records. In order to expedite claims, I authorize release of a copy of the original complete record to any requests for documentation by the insurance carrier or it representatives.

By signing below, I indicate my understanding of the above, agreement to the above terms and conditions, and that the above has been explained to me in terms that I understand. By signing below I also indicate that I have asked any questions I might have about the above terms and conditions and my questions have been answered.

I agree to evaluation and treatment and agree to the above terms and conditions, and release of information.

Signature _____ Date _____

Signature of Witness _____