REQUEST FOR INDIVIDUAL THERAPY

SPEECH THERAPY | OCCUPATIONAL THERAPY | READING THERAPY | MUSIC THERAPY

As part of our ongoing mission to provide children with speech, language, and learning differences with the tools to reach their full potential, Capitol School offers onsite individual speech/language therapy, occupational therapy, reading therapy (academic language therapy) and music therapy.

Sessions are 50 minutes in length unless noted otherwise and times will depend on the availability of our therapists. We will try to accommodate your preference for time. Payment in advance for **four sessions** is required for all therapies. Once your four sessions are completed, a request for payment for additional sessions will be sent home. Treatment receipts are provided at the end of each month of service.

To request individual therapy, please fill out the following information, sign the consent form and return email to CSA@capitolschool.com, and we will contact you to schedule a therapy time.

Child's Name: _____ Teacher: _____

Parent's Name: _____

Email: _____ Phone: _____

PATIENT CONSENT

As required by the 1996 Health Insurance Portability and Accountability Act (HIPAA) we must obtain a written consent from you to comply with federal Standards for Privacy of Individually Identifiable Patient Information (the "privacy rule").

I hereby authorize Capitol School of Austin to provide evaluation and therapy services to _____. I further authorize Capitol School of Austin for therapy services to release and receive protected health information, which may include medical, therapy and billing records for activities related to treatment, payment and health care operations.

I understand that I can revoke this consent at any time, except to the extent that action has already taken place and, if not expressly revoked earlier; it shall expire on the following date or if not specified, in one year from the date signed below.

_____ (date, event, or condition that you wish consent will expire)

Dated this _____ day of _____ , 20 _____

Signature of Parent/Guardian of minor: _____ Date: _____

Witness: _____ Date: _____

SELECT REQUESTED SERVICE

– REFER TO CLINIC FEE SHEET FOR PRICING –

○ **SPEECH THERAPY:**
- _____ **50 minute session**
- _____ **25 minute session**
- _____ One Day a Week
- _____ Two Days a Week
- _____ Other: _____

○ **OCCUPATIONAL THERAPY:**
- _____ **50 minute session**
- _____ **25 minute session**
- _____ One Day a Week
- _____ Two Days a Week
- _____ Other: _____

○ **READING THERAPY**
(ACADEMIC LANGUAGE THERAPY):
- _____ **50 minute session**
- _____ **25 minute session**
- _____ One Day a Week
- _____ Two Days a Week
- _____ Other: _____

○ **MUSIC THERAPY:**
- _____ **50 minute session**
- _____ **25 minute session**
- _____ One Day a Week
- _____ Two Days a Week
- _____ Other: _____

PLEASE INDICATE YOUR PREFERRED THERAPY TIME BLOCK:

- ○ Before School
- ○ During School Hours
- ○ Directly After School
- ○ Any Time After School

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