PEDIATRIC THERAPY ASSOCIATES *& Sports Medicine*

Patient Name: _____ Date of Birth: _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Pediatric Therapy Associates to furnish medical care and treatment to __ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian Signature: X_____________________________________ Date: ______________

Relationship to Patient (please check one): ☐Parent ☐Legal Guardian ☐Other: ________________

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicaid, private insurance and third party payors to Pediatric Therapy Associates. A photocopy of this assignment is to be considered as valid as the original. **I hereby authorize PTA to release all information necessary, including Medical Records, to secure payment.**

Patient/Guardian Signature: X_____________________________________ Date: ______________

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT HANDBOOK AND ENCLOSED POLICIES AND PROCEDURES

I have received the PTA Family Welcome Book and will familiarize myself with the enclosed Policies and Procedures. I specifically acknowledge and agree to the following: (Please initial each item below)

Summary of Financial Policy

PTA will file claims to your insurance as a courtesy to you. If your insurance does not apply claims to your benefits, we offer a courtesy discount rate of $30 per 15 minutes. If your insurance carrier does not remit payment within 6 treatment sessions, any balance will be due in full from you. If insurance pays on your claims, you will be refunded any overpayment made. Further details regarding our financial policy and billing procedures can be found in your Family Welcome Book.

Your estimated insurance benefits for Speech Therapy, payment to be collected at the time of service:

# of allowable visits: _____ visits per _____.
Estimated patient payment per Evaluation visit: _____
Estimated patient payment per Treatment visit: _____

_X____ I understand and agree to the Financial Policy and my responsibility for the payment of my account.

Summary of Cancellation and No Show Policy

PTA policy requires a 24-hour cancellation notice unless your cancellation is due to an illness or emergency. Consistent attendance is very important in helping your child reach his/her therapeutic goals. **Three consecutive no-shows, or more than 3 absences out of 8 appointments will be considered excessive and may result in losing your dedicated time spot.**

_X____ I understand and agree to the Cancellation and No Show Policy.

Patient Name: __ Date of Birth: __

Summary of Caregiver Attendance Policy

Caregivers are encouraged to attend therapy sessions when it would be therapeutically beneficial for the patient. **We reserve the last 5 minutes of your session time for documentation of your child's session and consultation with you regarding progress and any changes to the home care plan. If at any time you would like to have your consultation in private, please inform your therapist.** Please do not leave children unattended in the waiting room or leave the building while your child is in session.

_X____ I understand and agree to the Caregiver Attendance Policy.

Summary of Electronic Communication Policy

With a caregiver's permission, we may use email communication for notification and reminders regarding scheduling and/or cancellations in the event that we cannot reach you by phone or in person.

_X____ I DO/DO NOT (circle one) agree to the limited use of email for the purposes of scheduling only.

My preferred email address is ________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTIFICATION OF PATIENT PRIVACY PRACTICE

I understand that I have certain rights to privacy regarding my child's protected health information (PHI). These rights are provided to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have also been informed of and given the right to review and secure a copy of PTA's Notice of Privacy Practices, found in the Patient Welcome Book, which contains a more complete description of the uses and disclosures of my child's PHI and my rights under HIPAA

I have received a copy of the Notice of Privacy Practices for Pediatric Therapy Associates to review.

Patient/Guardian Signature: X_____________________________________ Date: _______________

PTA Representative/Witness Signature: _____________________________ Date: _______________

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practice because:

- ☐ An emergency existed and a signature was not possible at the time
- ☐ The individual refused to sign
- ☐ A copy was mailed with a request for a signature by return mail
- ☐ Unable to communicate with patient for the following reason: ________________________
- ☐ Other:__________________________________

PEDIATRIC THERAPY ASSOCIATES & Sports Medicine

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: __ Date of Birth: __

As required by the Privacy Regulations, this practice may not use or disclose your PHI (protected health information) except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(ies), or business associates of this office:

_____

Patient Health Information authorized to be disclosed:

Evaluations, Progress Notes, and/or Treatment Notes

For the specific purpose of (describe in detail):

Coordination of Care for therapy: Choose Discipline

Effective dates for this authorization: _____through _____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Patient/Guardian Signature: X_____________________________________ Date: _______________

PTA Representative/Witness Signature: ______________________________ Date: _______________