TheraPlay at Home

Pediatric Therapy Services

Phone: 407-790-5601 Fax: 407-602-7858 info@theraplayathome.com

Consent & Authorization Forms:
Contract between Client and TheraPlay at Home

Child's Name: _____ Child's Date of Birth: _____

Please initial each paragraph if in agreement:

_____ ***Authorization of Treatment:*** I voluntarily give permission for a licensed therapist from *TheraPlay at Home* (also referred to as the Therapy Provider) to touch, evaluate, and treat my child as directed by my doctor. I am aware that therapy is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments. I understand it is my choice to choose *TheraPlay at Home* to provide therapy services to my child.

_____ ***Medical Release Authorization:*** I authorize the release of any medical or other information necessary to process health insurance claims.

_____ ***Assignment of Benefits:*** I fully understand and agree to this assignment of benefits for insurance or grant reimbursement. I agree to allow *TheraPlay at Home* to file claims to my insurance company or grant and I am authorizing the assignment of benefits to be issued directly to *TheraPlay at Home*, which would otherwise be payable to me. I understand that insurance and grant payments, if any, made payable and sent directly to me by the insurance or grant company for therapy services rendered will be endorsed by me and given immediately to the Therapy Provider.

_____ ***Financial Responsibility:*** I understand and agree that I am responsible for the payment of any and all sums that may become due for the therapy services provided to my child, even if not paid by my insurance company. These may include, but are not limited to: deductible, co-payments, out-of-pocket payments, payments made to me by the insurance company for therapy services, and fees for non-covered services. I understand that as a policyholder, it is my responsibility to know the insurance policy's benefits and limitations and to initiate any inquiries regarding denial of services. I understand it is my responsibility to inform TheraPlay of any and all insurance policies in place and active that cover my child's therapy services.

_____ ***Cancellation Policy and non-payment of fees:*** As a professional courtesy to the treating therapist, I agree to give *at least* 24 hours' notice if therapy appointments need to be cancelled. If I do not give adequate notice, the 1st incident will be a no-fee "freebie," regardless of reason. On additional incidents, I understand there is a $25 late-cancellation fee, or a $50 "no-show" fee, which is not a billable charge to my insurance or grant. I attach a credit card form and understand that my card will be billed for any non-payment of fees. I understand that if I fail to attend therapy without notice, or cancel late, 3 times then we may be put on hold to enable a patient with availability to take our appointment time. This is cumulative across all therapies we use at TheraPlay.

_____ ***Notice of Privacy Practices Consent Form****:* I have received and read, or am familiar with, the HIPAA compliance notice in the *Notice of Privacy Practices*. I understand and accept the terms.

I have read the above paragraphs and I certify that I understand their full content.

_____

Parent/Guardian (Print)

_____ _____

Parent/Guardian (Signature) Date