TherapyWorks 4 Kids, LLC™

Patient Name _____

Consent to Treat

I,_____(parent/guardian), knowing that _____ (child) has a diagnosis requiring Occupational, Speech, or Physical Therapy treatment (OT, ST or PT) voluntarily consents to such care for the aforementioned child by TherapyWorks 4 Kids, LLC as may be beneficial in the professional judgment of the child's therapist(s) and primary care physician. I am aware that no guarantee has been made as to the effect of OT, ST, or PT on my child.

Parent Initials _____

I am aware that gross motor play is often encouraged during therapy. Use of swinging, running, climbing, and jumping assist with a variety of skills and performance components the therapist may need to address. I consent to use of gross motor play and exempt my child, therapist(s) and employee(s) and owner(s) of TherapyWorks 4 Kids, LLC, from any injury resulting from this type of play.

Parent Initials _____

I am aware that persons not listed on the prescription are not allowed into the treatment areas and will be under my direct supervision at all times. TherapyWorks 4 Kids, LLC is not responsible for any accident/injury that occurs as a result of unauthorized or unsupervised use of the facility and/or equipment.

Parent Initials _____

My child has my permission to participate in a natural environment setting during therapy sessions. I understand that this presumes the presence of a wide variety of other people including other children, siblings, parents, professionals, volunteers, or students. In addition to the natural play environment on location; my child may participate in therapy in the home, school, and community to maximize carryover of functional skills.

Parent Initials _____

I authorize photographs/video to be used for the following purposes: (**Parents ONLY initial approved purposes**)

Track your child's therapy progress _____
Display in clinic _____
Display on website _____

Financial Authorization & Responsibility

I hereby authorize TherapyWorks 4 Kids, LLC Billing department to bill my insurance company for direct reimbursement of therapy services rendered to my child. Unless otherwise noted, benefit payment will be assigned directly to TherapyWorks 4 Kids, LLC. All copays and payments are due at the time of service. I understand that patient or patient's family is responsible to pay all fees accrued for services rendered, regardless of insurance verification or anticipated insurance coverage, if insurance company refuses to pay provider a portion of the fees or in full. I agree to pay all fees within 30 days after bill has been mailed, and understand that any fees not paid within 30 days will result in a 10% or greater late fee. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated banking, legal and/or collection fees I understand that I am advised to fully know and understand my insurance benefits prior to my child receiving therapy services. I understand that all insurance plans are different and it is impossible for TherapyWorks 4 Kids, LLC to know the specifics of my plan and/or if my plan will reimburse for services received. I agree to notify TherapyWorks 4 Kids, LLC if my insurance coverage changes. I understand that I am ultimately responsible for payment of all services received.

Parent Initials _____

I am aware that not all fees are billable to insurance companies such as materials, books, equipment, school conferences, and therapist consultations (in person or phone) and will be billed directly to the responsible party or guardian. I understand that I am responsible for payment of these services not billable to my insurance company.

Parent Initials _____

I have been provided a copy of the Notice of Privacy Practices.

Parent Initials _____

Parent/Guardian Signature:_____

Parent/Guardian Printed Name:_____

Date: _____