



AUTHORIZATIONS AND CONSENTS (Page 1 of 3)

Patient's Name:	DOB:	Today's Date:
CONSENT FOR DIAGNOSTIC PROCEDURES AND TREATMENT		
<p>"This is to certify that I, the undersigned, consent to the administration of treatment to the above named patient at PediaFlex Therapy Center, LLC. I consent to any procedures of examination and any other service rendered to me under the general and specific instruction of my therapist. I understand that except in emergency, all special procedures will be discussed with me by my therapist."</p>		
NOTICE OF PRIVACY PRACTICES		
<p>"I hereby acknowledge that a copy of PediaFlex Therapy Center, LLC Notice of Privacy Practices has been made available to me and which I have the right to review before I sign this. I further acknowledge that I may request a copy of any amended notice of Privacy Practices. I understand that I have the right to request that PediaFlex Therapy center, LLC restrict how my protected health information is used and disclosed for treatment, payment and health care operations."</p>		
CONSENT FOR PHOTOGRAPHY		
<p>"This authorization allows PediaFlex Therapy Center, LLC to use and edit photography for publications, to ensure effective care, for posting on its web site, for presentations, for the development of learning materials and for planning of therapy services. It is understood that the photography is the property of PediaFlex Therapy Center, LLC and that once this material is published, PediaFlex Therapy Center, LLC can not ensure its use or dissemination. Photographs of the individual may be taken during play, treatment, assessment, or during other activities. A brief description of the photograph and its setting or action may be used with the photograph. A brief comment from family members or patients regarding their progress and care may be included with the photograph in its use. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent, except on action already taken. I recognize that health records are protected by the HIPAA Privacy Rule. I also understand that if I refuse authorization, such refusal will not interfere with my ability to obtain therapy services at PediaFlex Therapy Center, LLC."</p>		
RISK OF INJURY		
<p>"I realize that, as with any physical activity there is a possible risk of injury to my child while participating in this activity or programs. I agree to assume the risk of injury for which he/she might suffer while participating in the activity or program. I will not hold PediaFlex Therapy Center, LLC or its respective members, official agents or employees liable for any injuries which he/she may suffer while participating in any therapy or program. I waive and release forever all claims for damages against PediaFlex Therapy Center, LLC, or its respective members, official agents or employees, for any and all injuries and/or losses he/she may sustain while participation in activities or programs. I realize that in the event of serious injury, PediaFlex Therapy Center, LLC, its respective members, official agents or employees may seek emergency medical treatment and transportation, if needed, and release client records upon request to the authorized individual or agency involved in the medical emergency treatment, for which I, the patient and family, am ultimately responsible for payment of. This authorization includes x-ray, surgery, hospitalization, medication or any treatment procedure deemed "life saving" by the physician. I have shared and disclosed all physical, mental, emotional, behavioral, and other pertinent information with PediaFlex Therapy Center, LLC that may affect patient's safety during participation in activities."</p>		

AUTHORIZATIONS AND CONSENTS (Page 2 of 3)

MISSED APPOINTMENT POLICY

"I acknowledge that PediaFlex Therapy Center, LLC strives to improve the abilities of all children. If my appointments are not kept progress will be impacted. I also acknowledge that any cancellation of an appointment is requested at least 24 hours in advance. If 24 hours is not provided for cancellations, or appointments are missed without a call, I will be charged \$35.00 for the appointment. I understand that these missed appointments cannot be billed to my insurance company. In addition, if I have a pattern of cancellation I will risk losing my child's appointment time."

DISCHARGE POLICY

"I acknowledge and am aware that my child will be discharged from services when the goals and objectives have been achieved, when my child's scores are within the average range, and/or when progress is not being made."

WAITING ROOM SUPERVISION POLICY

"I acknowledge that PediaFlex Therapy Center, LLC is sharing a waiting room with Advanced Therapy Solutions for families while the children are being seen. I understand that this is not a supervised waiting room. Any injury to my child is not the responsibility of PediaFlex Therapy Center LLC. I understand that my children must be supervised by me as an adult at all times. I understand that PediaFlex Therapy Center, LLC provides toys and books for the children's use and that I am responsible to help keep the waiting area clean and neat for everyone's benefit. I understand that there is a lot of traffic through the waiting room and ensure that the toys my children play with are not an obstacle to others."

RELEASE AND/OR REQUEST THE RELEASE OF RECORDS/HEALTH INFORMATION

"I am authorizing to release and/or requesting the release of medical, health, educational, psychological, psychiatric, drug, alcohol, HIV related information, and/or health information, if appropriate to/from those listed below. Information to be shared or requested may include: evaluation results, treatment notes, plan of care, recommendations, discharge plan, and/or patient background information. This information may be used to: ensure effective care of therapy services, complete assessments, develop a plan of care, make appropriate referrals, and/or plan discharge. This consent is subject to revocation at any time except to the extent that action has been taken and withdrawal of consent shall be addressed in writing to PediaFlex Therapy Center LLC."

Check Appropriate Boxes of your consent: Patient/Parent Pediatrician Other, please specify:

Name:

Phone:

Name:

Phone:

Name:

Phone:

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EXPLANATION OF FEES AND BILLING

Charges for services rendered by PediaFlex Therapy Center, LLC are based upon the procedures which the physical therapist, in his or her professional judgment, deems necessary to enable the patient to reach their rehabilitative goals. The patient/family is ultimately responsible for payment of all fees for physical therapy services provided. **Payment in full is expected at the time the services are rendered.** Pediaflex **does not** participate in any private insurance plan networks and is not responsible for processing claims to insurance companies. However, PediaFlex will provide all necessary diagnostic coding, treatment/procedural coding and documentation of services provided for the family to submit for out-of-network claim processing. It is important that *you* determine and understand your individual health plan's **out-of-network** PT benefits. To learn more about your coverage, please call the member services number on your insurance card. When you're speaking to the member services representative, you will want to fully understand your plans out-of-network deductible, co-insurance, out-of-pocket maximums, allowed number of therapy visits, prior authorization requirements, and claim submission procedure.

Private Pay Service Charge Rate: \$37.00 per 15 minutes of service time. The charges which make up a patient's bill can be grouped into three categories:

1. **Initial Evaluation and Periodic Re-Evaluation** - The evaluations are performed by a licensed physical therapist and the charge for these services are billed in 15 minute increments. Time spent in interview and history taking, records review, assessment, and calculation and analysis of standardized testing and documentation time are all parts of the evaluation process.
2. **Direct Physical Therapy Treatment** - The treatments are performed by a licensed physical therapist and the charge for these services are billed in 15 minute increments. These include such treatments as therapeutic exercises, manual therapy, functional activity, and neuromuscular re-education; and attendance to out of office activities on your child's behalf, such as PPT's or community events.
3. **Documentation and Reporting** – Periodically families request that we provide documentation for pediatricians, specialists, or other community programs. These documents and reports are completed by a licensed physical therapist and the charges for these services are billed in 15 minute increments.

"I authorize PediaFlex Therapy Center, LLC to bill me directly at the time of service for my child's therapy services. I understand that PediaFlex does not participate in any insurance plan networks. I understand and agree that I am responsible for determining my insurance plans out-of-network coverage of physical therapy services. I understand that some insurance companies require medical or administrative pre-authorization for treatment, and/or have reimbursement limits on therapy treatments. I understand that I am fully responsible for submitting claims and documentation to my insurance company for reimbursement. I understand that if my account should remain unpaid for more than 90 days, I will be subject to a finance charge of 5% per month. I understand that PediaFlex has the right to discontinue future treatments if payments are outstanding. I understand and agree that I am fully responsible for my child's therapy charges, and I agree to pay at the time of service."

SIGNATURE OF AUTHORIZATION AND CONSENT

"I have read all of the above information and I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent, except on action already taken. I recognize that health records are protected by the HIPAA Privacy Rule. I also understand that if I refuse authorization, such refusal may interfere with my ability to obtain therapy services at PediaFlex Therapy Center, LLC."

Name: _____ Signature: _____ Date: _____ Relation: Mother Father Guardian