TheraPlay Spot
PEDIATRIC OCCUPATIONAL & PHYSICAL THERAPY
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Consent & Authorization Form
Contract between Client and TheraPlay Spot LLC

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

Authorization of Treatment: I voluntarily give permission for a licensed therapist from *TheraPlay Spot, LLC* 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 Spot, LLC* 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 reimbursement. I agree to allow *TheraPlay Spot, LLC* to file claims to my insurance company and I am authorizing the assignment of benefits to be issued directly to *TheraPlay Spot, LLC*, which would otherwise be payable to me. I understand that insurance payments, if any, made payable and sent directly to me by the insurance company for therapy services rendered will be endorsed by me and given immediately to TheraPlay Spot.

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. TheraPlay Spot reserves the right to charge a 5% finance fee for any past due balances over 30 days.

Initial Fee Policy: I understand there is a $75 nonrefundable initial fee that will be charged, to the credit card or bank account provided, 2 business days prior to the evaluation. Upon completion of the evaluation the initial fee will be applied to your account towards services that may become due.

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.

Waiver & Release*:* My signature holds TheraPlay Spot harmless from any and all liability or cause of action of any kind as a result of my failure to notify—or my refusal to allow or receive—emergency and or medical services.

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

_____
Parent/Guardian (Print)

_____ _____
Parent/Guardian (Signature) Date