TRIANGLE
THERAPY SERVICES

Consent for Services

Name of Client: ____ D.O.B: _________________

Address: ____
Street or PO Box City State Zip

I hereby grant my permission to for the above named client to receive treatment services at Triangle Therapy Services as they have been outlined to me. I have received a copy of the Facility Policies, and understand the nature of the service that I will receive. By initialing the following items, I acknowledge the policies at Triangle Therapy Services, and my responsibilities as stated below:

MEDICAL INFORMATION AUTHORIZATION: I hereby give my consent to any physician, hospital, school or clinic to release any and all records pertaining to medical history, services, or treatment as it applies to my treatment services at this facility. This information will be treated as confidential. I also give my consent for Triangle Therapy Services to release information relating to my diagnosis/treatment at this facility to my insurance carrier, my physician, school, or other agencies that I may designate.
________(Initial here)
I acknowledge that I have received Notice of Protected Health Information Practices according to the Health Insurance Portability and Accountability Act (HIPAA)
_______ (Initial here)

FINANCIAL RESPONSIBILITY: I authorize billing and payment of medical benefits to Triangle Therapy Services, LLC from my insurance company. However, I assume full financial responsibility for the therapy services that I will receive, regardless of third party coverage. I assume full financial responsibility in the event that my health carrier denies insurance payment in part or in full. I understand fees for service, co-pays, or co-insurance are due at the time therapy services are rendered unless other arrangements have been made.
________(Initial here)

CANCELLATIONS/MAKE-UPS: I understand that if I must cancel a session, a 24-hour notice is required. A $20.00 cancellation fee will be charged for less than 24 hour notice or no shows. I UNDERSTAND THAT FAILURE TO NOTIFY TRIANGLE THERAPY SERVICES OF CANCELLATIONS MAY RESULT IN DISCHARGE FROM THE PROGRAM.
________(Initial here)

CONSENT FOR PICTURE AND VOICE: I hereby acknowledge that photographs, slides, videotape footage, and/or audio recordings may be made of my therapy sessions at Triangle Therapy Services. I waive my rights to privacy so that members of my family, and/or professional staff may observe these media, which will be used for analysis to improve and document treatment. They may also be used for educational purposes, research purposes, and for the purpose of training other professionals to better understand special needs and treatment methods. They may be posted on the Triangle Therapy website or Triangle Therapy facebook page for public information purposes without names being used.

Permission given: Yes No (circle one)
________(Initial here)

The undersigned certifies that he/she has read the above and has received a copy of the Facility Policies. The undersigned also certifies that he/she is the client or is the duly authorized client guardian and can execute the above and accept its terms on behalf of the client.

Signature: ____ Date: ___________________
Client or Client's Parent/Guardian