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

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 Spot, LLC* (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 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 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: my deductible, co-payments, co-insurance 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. We reserve the right to charge a 5% finance fee for any past due balances.

_____ ***Cancellation Policy:*** As a professional courtesy to the treating therapist—who works at a scheduled time reserved specifically for my child—I agree to give *at least* a day's notice if therapy appointments need to be cancelled or rescheduled. Also, I agree that my child will have an 80% or higher attendance rate. If there are 2 incidents of no-shows or 3 incidents of same-day cancellations within a 6-month period, or if cancellations or reschedules are deemed excessive (that is, more than 20% of the time), I understand that my child could be terminated from therapy services and another child may be offered my timeslot.

_____ ***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

_____ _____
TheraPlay Spot, LLC Representative (Signature) Date