Insurance Authorization, Assignment of Benefits and Consent for Treatment

I hereby authorize Pediatric Therapy Services, Inc. to furnish all information to insurance carriers and/or Medicaid concerning (Patient's Name) _____, diagnosis and or treatments. I hereby assign to Pediatric Therapy Services, Inc. (providers) all payments for therapy and related services rendered to my dependents. Should the insurance company send payment directly to me, I will endorse said check over to Pediatric Therapy Services, Inc. _____ (initials)

I understand that I am responsible for any amount not covered by insurance: this includes any course of treatment that is not a covered benefit, including DME products. _____(initials)

I understand that I am responsible for notifying Pediatric Therapy Services, Inc. of any changes in my insurance coverage. If I am delinquent in updating this information and charges are denied, I understand that I am responsible for these charges. _____ (initials)

I understand that I may be charged 1.5% interest rate per month on any unpaid balance and that I am responsible for any costs incurred in collection of said balance should that become necessary. _____ (initials)

I understand that I will be charged a $25 fee for "No Show" appointments. _____ (initials)

I authorize Pediatric Therapy Services, Inc. to initiate a complaint to the Insurance commissioner for any reason on my behalf. _____ (initials)

My signature below indicates I understand and accept this policy.

_____ _____ _____

Signature of legal guardian Printed Name Date

Consent to release and obtain medical information, or information relating to treatment and health care operations

I, _____,(name of patient representative) do hereby consent to Pediatric Therapy Services, Inc. and any physicians, agencies, schools, health care providers, or authorized agents examining or treating the above named child/patient to use or disclose protected health information for treatment, and payment for health care operations.

_____ (Signature) _____ (Date)

Patient's health care information will not be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

Signature Date

CONSENT FOR TREATMENT

I hereby give my permission to the staff of Pediatric Therapy Services to carry out all necessary diagnostic, assessment, and treatment activities which will address the needs of the patient named above.

Signature:_____ Relationship:_____ Date:_____

I acknowledge that I have read a copy of the Pediatric Therapy Services, Inc. **"Notice of Privacy Practices."**
I have read and understand the above and agree to comply.

Signature:_____ Relationship:_____ Date:_____

A photocopy of this Assignment shall be considered as effective as the original.

This entire consent is valid from date of signature until closure of all patient's files.