PATIENT CONSENT FORM

Patient Name: _____ **Date of Birth:** _____ **Sex:** _____

Address: _____

Parent/Guardian Name: _____

Phone: _____ **Cell:** _____ **Work:** _____

Insurance: _____ **ID#:**_____ **S.S. #:** _____

Doctor Name: _____ **Phone:** _____

Diagnosis: _____

Concerns:_____

_____

_____

Authorization for Treatment: The undersigned hereby authorizes Therapy Station, Inc. employees and/or contractors (referred to as "Providers") to render physical therapy, occupational therapy, speech therapy, early intervention, audiology, psychological services or other related services (referred to as "therapy services") that Provider and/or patient's physician determine to be medically necessary. The undersigned agree to cooperate with all reasonable requests of Provider in connection with Provider's rendering of therapy services.

Assignment of Benefits: The undersigned hereby assign and transfer to Provider the right to all third party payments (including Medicaid and/or private insurance benefits) to which the undersigned may be or become entitled to for therapy services rendered by the Provider. The undersigned hereby authorizes Provider to apply and file for all such benefit payments on behalf of the patient and direct that such payments be made directly to the Provider. Any insurance benefit payments received by the undersigned for services rendered by the Provider shall be paid to the Provider.

Payment Responsibility: The undersigned shall be financially responsible for any portion of the Provider's charges that is not paid by insurance, except in the event of covered services provided to Medicaid recipients. The undersigned agrees to execute any and all documents and perform any acts that Provider may reasonably request to ensure that all third party benefits for therapy services are paid to the Provider.

Release Information: The undersigned hereby certifies that all information provided to Provider by the undersigned is true and accurate. The undersigned hereby authorizes Provider to disclose any information, medical and non-medical, furnished to or obtained by Provider in connection with patient's diagnosis and/or treatment, to any physician, government agency (including the U.S. Department of Health and Human Services, or any of its intermediaries or carriers), insurance company or health care provider requesting such information. The undersigned agrees to allow Provider access to the patient's medical records and agrees to allow Provider to make copies of such records. The undersigned consents to the discussing by Provider of the patient's medical condition with the patient's family members for medical or claims management purposes.

Cancellation Policy: To ensure that our therapists can most effectively plan their time to meet the needs of the children they provide services for, parents are asked to call Therapy Station, Inc. or the treating Therapist with any **cancellation with at least 24 hour notice.** Therapy Station's voice mail is available 24 hours/day. We encourage families to re-schedule cancelled sessions whenever possible. Therapy Station, Inc. is closed on major holidays. However, therapists often choose to see clients on the other holidays during the year and during school vacations. Please make arrangements if you will not be attending on those days. Consistent attendance is important to ensure your child's optimal progress. **Please note, if a parent/guardian cancels more that 20% of treatment sessions for any 8-week period or miss three (3) consecutive treatment sessions, we reserve the right to discharge the patient immediately, without notice.**

Illness: Provider may ask for a doctor's note for all illnesses in which the child is contagious or can infect other children or when an illness causes more than one (1) missed scheduled therapy session.

Photo Consent: The undersigned hereby consents for Therapy Station, Inc. to photograph their child for the purpose of documentation and/or presentation and/or marketing purposes.

I have read and understand the above information. I acknowledge by signing below, I hereby accept the terms and conditions and give consent for my child to receive treatment.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Name (printed): _____