www.atozpediatrictherapy.com

2021 CONSENT FORM

Name of Child: _____ Date of Birth: _____

I, _____, herby consent to the evaluation, treatment, and insurance billing for my child. The assessment may include: observation of the child; formal and informal testing; follow up visits; and ongoing intervention. I understand that the results of the Assessment and the Plan of Care will be shared with me. I agree to comply with the Plan of Care with the best of my ability for the best outcome for my child. I understand that at any given time I have the right to refuse care and revoke my consent for treatment with A to Z Pediatric Therapy, LLC.

I consent to and assume all risks and hazards of and incidental to the participation of the above named child in the activities of A to Z Pediatric Therapy, LLC, and agree to indemnify the said organization and its officers, servants, or agents nominated or appointed by or on its behalf against all loss from any claim hereafter made against it, them or any of them by or on behalf of said child and arising directly or indirectly from such participation.

A to Z Pediatric Therapy, LLC deem it their responsibility to provide effective and quality treatments to their families in a safe environment. If a therapist feels that a situation is unsafe for them personally, A to Z Pediatric Therapy, LLC, reserves the right to discontinue services.

A to Z Pediatric Therapy, LLC has an obligation and responsibility to their professional guidelines and standards of practice. Therefore, when a child no longer qualifies for services or therapy is no longer effective or productive for various reasons, a discharge summary will be completed. It is the right of the caregiver at any time for any reason to request a change in providers.

SESSION PARTICIPATION AND CANCELLATION POLICY:

_____I agree to actively participate in the scheduling of my child's session and understand that 3 unscheduled absences may result in discharge from therapy services. In addition, I agree to be available to assist my child's therapist regarding sessions; in the compliance with the Plan of Care; and following the home program under the direction of my child's therapist.

INSURANCE AND PAYMENT POLICY CONSENT:

_____I authorize A to Z Pediatric Therapy, LLC, to submit claims to my insurance company on my behalf and authorize my insurance company to pay benefits as well as release the explanation of benefits to A to Z Pediatric Therapy. In the event that a therapy service is not covered by my private insurance and no additional insurance is active such as Medicaid, I am financially responsible for any balance due.

_____I understand that I must notify A to Z Pediatric Therapy, LLC immediately should there be a change in insurance or personal information. Failure to do so will result in my responsibility for payment of services if insurance denies services due to lack of authorization and/or verification of benefits.

_____I understand that verification of benefits does not ensure payment of services and I am financially responsible for any balance due.

_____I authorize my insurance and Medicaid benefits be paid directly to A to Z Pediatric Therapy, LLC.

RELEASE OF INFORMATION CONSENT:

_____I authorize A to Z Pediatric Therapy, LLC to release information to health professionals, insurance companies, or Medicaid in order to process all medical claims on the patient's behalf through written or verbal communication, via regular mail, electronically, or by fax.

_____
Patient Name

_____
Parent/Caregiver Name

_____ _____
Parent/Caregiver Signature Date