Parent or Legal Guardian Informed Consent for Services

I consent for my child to receive evaluation and/or therapy services from Pediatric Therapy Network and their treating therapists according to my child's physician's orders. I understand that Pediatric Therapy Network will bill my insurance company first. If the service is not covered by my insurance, I agree to pay for the service in-full immediately upon receiving a bill from Pediatric Therapy Network. If my child has NC Medicaid, PTN will accept the reimbursement as payment in full. I also understand that it is my responsibility to keep my child's insurance and/or Medicaid coverage in effect. I agree to inform PTN of any changes in my child's insurance coverage. I understand that if I do not keep my insurance or Medicaid coverage in effect, and do not inform PTN, I agree to pay the usual and customary fee for services provided during the period without coverage. If the below named child needs emergency medical care while receiving services, I give permission for PTN or their treating therapists, to obtain such care, and I agree to be financially responsible for the services.

Print Child's Name ______________________ Date of Birth ______________________

Parent or Legal Guardian Signature ______________________ Date ______________________

DIRECT ASSIGNMENT OF INSURANCE PAYMENT

Please bill my Insurance:
When Pediatric Therapy Network files for third party insurance payment under my policy benefits, and they are otherwise payable to me as the policyholder, I authorize payment directly to Pediatric Therapy Network. If my policy prohibits direct payment to a doctor or treatment facility, the payment should be made to me as the policyholder, and I agree to reimburse the full amount to Pediatric Therapy Network. This is a direct assignment of rights and benefits under my insurance policy. Further, I agree to pay to Pediatric Therapy Network, in a timely manner, any balance that remains after payment of insurance benefits. A photocopy of this assignment shall be considered as effective as the original.

I have read and understand all of the above, and I agree to all of the conditions and information. I understand that this agreement will remain in effect the duration of treatment, and that I can revoke this agreement at any time in writing, except for services that have already been provided.

Policyholder/Legal Guardian Responsible for Payment ______________________ Date ______________________

Please bill me directly: ***(Sign the following section ONLY if you wish to be personally billed for services; otherwise leave blank.)***
I request that I, in accordance with the Health Insurance Portability and Accountability Act of 1996 ('HIPPA"), 45CFR 164.522 that Pediatric Therapy Network **NOT** contact my insurance carrier. In doing so, I understand the policy benefits will not apply to my charge for services and that **I WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICES. PLEASE BILL BE PERSONALLY AT THE TIME THAT SERVICES ARE RENDERED.**

Policyholder/Legal Guardian Responsible for Payment ______________________ Date ______________________

RELEASE OF INFORMATION

I authorize Pediatric Therapy Network, and/or their treating therapists to obtain/release information, as necessary, for the purpose of filling for insurance compensation or for requesting compensation from Federal or State resources that appropriate payment for services my child receives. I understand that in order for my child to be provided with the best possible services, PTN must have my permission to communicate with other providers involved in my child's care. I hereby grant permission for PTN and their treating therapists to obtain/share information with the following agencies/persons: ***(Please list the names of all physicians, practices, and agencies that are involved in your child's care)***

Primary Physicians/practice name: ______________________
Other Current Service Providers: ______________________
Physicians/Specialists: ______________________
Children's Developmental Services Agency (indicate which office): ______________________
Daycare: ______________________
Preschool Program: ______________________
School System: ______________________ Current IEP Date: ______________________ ****** Provide copy of current IEP to office staff*****
Previous Providers: ______________________

Parent or Legal Guardian Signature ______________________ Date ______________________

ACKOWLEDGMENT OF PRIVACY NOTICE and CLIENT PRIVACY RIGHTS

As a client of PTN, you have certain rights regarding your child's services and the protection of yours/your child's health care information.
"Notice of Privacy Practices" has been given to you today.
I have received a copy of the "Notice of Privacy Practices" and its contents have been explained to me in a manner in which I understand.

Parent or Legal Guardian Signature ______________________ Date ______________________

Pediatric Therapy Network, LLC. **NOTICE OF PRIVACY PRACTICES AND CLIENT PRIVACY RIGHTS**

Our Pledge to You

We understand that your child's health information is personal and we are committed to protecting it. We create a record of the care and services your child receives at our organization. We need this record to provide your child with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about your child, describes your rights, and our duties regarding the use and disclosure of this information.

The **Health Insurance Portability and Accountability Act of 1996 (HIPPA),** *45 CFR Parts 160 & 164,* **The Confidentiality Law,** *42 CFR Part 2, and the* **NC General Statutes 122c** protect your child's healthcare information.

Under these Laws:

1. Our staff cannot acknowledge their professional relationship with you or your child to any person, including you family and friends, without your written authorization or one of the exceptions listed below.
2. We may not disclose any information identifying your child as a client, except as permitted by law.
3. We must obtain your written consent before we can disclose information to your health insurer/Medicaid in order to be paid for your child's services. *If you do not authorize us to release information to your insurance company, then full payment will be required at the time of service.*
4. We may use and disclose your protected health information for health care operations:
   a. Our office staff, clinical staff, and case managers are authorized to review medical records for the purpose of providing client care and treatment.
   b. Support staff and billing staff are authorized to review protected health information for the purposes of carrying out their routine jobs:
   c. Staff members conducting quality assurance, utilization review, and peer review activities may access protected health care information when they perform their review responsibilities.
   d. Students, interns, and trainees who have signed a confidentiality agreement with us and are working with PTN staff members to help them practice and improve their skills may also access information.

The law allows use and disclosure of information *without* your written permission:

1. When law requires the use and/or disclosure.
2. When it is necessary for public health activities.
3. We may share information with a physician who referred you to our agency.
4. We may share information with a business associate of PTN. (A business associate is one who provides services to PTN or provides services on our behalf.)
5. For research, audit, or evaluations.
6. To report a crime committed against our personnel.
7. To medical personnel in a medical emergency.
8. If we believe you are a danger to yourself or to others, or if we believe that you are likely to commit a crime, we may share information with law enforcement.
9. To appropriate authorities to report suspected abuse or neglect.
10. As allowed by court of law.

Written Authorization for Disclosure of Information

Before we can use or disclose any information about your health in a manner that is not described above or in items 1-10, we must first obtain your specific written authorization allowing us to make the disclosure. You may revoke any such written authorization in writing except for action has already been taken.

Contact Form Our Office/Your Child's Therapist

We may contact you to provide appointment reminders, billing clarification, assess the quality of our services, or other health-related benefits and services that may be of interest to you. IF you choose not to be contacted by us via telephone, letters, email, text, or messages, document you objection in writing, and give it to your service provider.

Our Duties

We are required by law to maintain the privacy or your child's health information, to provide you with a notice of our legal duties and privacy practices with respect to your child's health information, and to abide by this notice. If there are any changes made to the terms of this notice, we will provide you with the changes in writing. All PTN staff has been trained in maintaining your confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

Client Privacy Rights

1. Under HIPAA, you have the right to request restriction on certain uses and disclosures of your health information. PTN is not required to agree to any restriction you request, but if we do agree, then we are bound by that agreement and may not use or disclose any information for which you have restricted, except as necessary in a medical emergency or as required by law.
2. You have the right to request that we communicate with you by alternative means or at an alternative location. We will accommodate such requests that are reasonable and will not request an explanation from you. For example: you may wish for us to call you at a different telephone number.
3. You have the right to inspect your record. Inspections must be scheduled with your primary provider and in some circumstances, requests may be denied. You also have a right to request a personal copy of your record for a fee. Pediatric Therapy Network must respond to your request within 30 days.
4. You have the right, with some exceptions, to amend healthcare information maintain in our records. All requests for amendments must be made in writing. Pediatric Therapy Network must respond to your request within 60 days.
5. You have the right to request and receive an accounting of disclosures of your health-related information made by PTN during the six years prior to your request (Not including disclosures made prior to April 14, 2003). We are required to provide a listing of all disclosures except the following for your treatment, for billing and collection of payment for your treatment, for our health care operations, made to or requested by you or that you authorized, occurring as a result of permitted uses and disclosures, made to individuals involved in your care, allowed by law of if the information released did not identify you.
6. You have the right to received a paper copy of this notice.

Client Grievances

PTN provides a policy regarding client grievances and complaints: If you have a grievance that cannot be resolved with your therapist, you should document your grievance and forward it to Pediatric Therapy Network, Attn: Privacy Officer PO Box 1290, Hickory NC 28603. You may file a complaint with PTN and/or the Secretary of the United States Department of Health and Human Services if you feel that your privacy rights have been violated under HIPAA. If you file a complaint, we will not take any action against your or change our treatment of you in any way. To file a complaint with Pediatric Therapy Network, document your complain in writing along with your full name, address, and phone number and forward it to our privacy officer.

Pediatric Therapy Network, LLC

Cancellation Policy

It is a policy of Pediatric Therapy Network that when a treatment session is to be cancelled by the family of a client, notification must be given to the treating therapist **no less than 24 hours** prior to the scheduled appointment. If due to illness or emergency, it is impossible to give such advanced notice, please call as soon as you know that you will not be available for the scheduled appointment.

This applies also when we provide services to your child in a childcare setting. Please call as soon as you know your child will be absent, so that we may plan accordingly and re-schedule their missed session. It is very important that you communicate to your child's therapist any changes in your child's daycare, preschool, or caregiver's schedule **in advance.**

Please be advised that if you miss 3 scheduled treatment sessions without notifying the treating therapist, treatment services may be terminated. Consistency and prescribed frequency of treatment are essential to your child's progress in therapy.

Although it is our goal to be punctual and considerate of families' schedules, Pediatric Therapy Network and its treating therapists reserve the right to arrive 15 minutes before or after scheduled appointment times without notifying the family. There are times when traffic, treatment schedules or other unforeseen delays occur, and we appreciate your patience and understanding as we strive to provide quality services in every way.

By signing this form, I agree to cooperate with the cancellation policy and scheduling of Pediatric Therapy Network and its treating therapists.

______________________________________ __________________________

Signature of Parent or Authorized Person: Date