4992 Bristol Industrial Way
Buford, GA 30518
Phone: (770) 904-6419 Fax: (770) 904-6418

PATIENT CONSENT AND POLICY AGREEMENT

_____ (initial) I. **Consent for Treatment**: I hereby authorize and voluntarily consent to Peach State Pediatric Therapy Inc., and its employees to provide the patient with basic treatments including medical and diagnosis procedures considered reasonably necessary by the patient's physician for the patient's current condition.

_____ (initial) II. **Uses and Disclosure of Health Information**: The patient's health record, including the original paper record and electronically stored health information is the property of Peach State Pediatric Therapy Inc. All patient care information shall be regarded as confidential and available only to authorized users. I consent to the disclosure of health record information to members of the medical, clinical, and professional staffs who have a right to access the information.

Peach State Pediatric Therapy Inc. uses health information about the patient for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care the patient receives. Peach State Pediatric Therapy Inc. may use or disclose identifiable health information without your authorization for several other reasons. Subject to certain requirements, Peach State Pediatric Therapy Inc. may give out health information without my authorization for public health purposes, auditing purposes, for research studies, and for emergencies. Peach State Pediatric Therapy Inc. provides information when required by law, such as for law enforcement in specific circumstances.

I understand in other situations that I will be asked for my written authorization before Peach State Pediatric Therapy Inc. uses or discloses any identifiable health information about the patient. I have the right to choose to sign an authorization to disclose information and later revoke that authorization for future uses. Peach State Pediatric Therapy Inc. may change their policies related to use and disclosure of health information at any time. Prior to Peach State Pediatric Therapy Inc. making any changes in their policy they will change the notice and have it accessible at their office for review or if additional copies are needed. For additional information related to privacy practices I may contact the privacy officer , Margaret Kuneyl OTR/L at (770) 904-6419. As an individual you have the right in most cases to:

-Look at/get copy of health information about the patient that Peach State Pediatric Therapy Inc. uses to make decisions about the patient.

-Request that incorrect or missing information be corrected or added respectively.

-Request in writing that Peach State Pediatric Therapy Inc. use or disclose patient information for treatment, payment, or related purposes except when authorized by, required by law, or emergency situations. Peach State Pediatric Therapy Inc. will consider this request but is not legally required to accept it. If I am concerned that my privacy rights have been violated or that I disagree with the decisions of Peach State Pediatric Therapy Inc. made about patient access information I can contact the privacy officer or send a written complaint to the US Department of Health and Human Services.

It is Peach State Pediatric Therapy Inc. legal duty to protect the privacy of the patient's information, provide this notice about information practices, and follow the information practices that are described in this notice.

_____ (initial) III. **Consent for Release of Information for Payment Purposes:**

I herby authorize Peach State Pediatric Therapy Inc. to release to any insurance carrier, employer, government or social service agency, or other payer or provider of medical benefits which may or will pay for any part of medical expenses incurred, any information pertaining to the patient's care, for the purpose

of evaluating and processing claims for payment for the patients care with Peach State Pediatric Therapy Inc. This is to include release to patient's physician for their ability to procure payment for services with Peach State Pediatric Therapy Inc. I further authorize the disclosing of information regarding the patient's medical care and/or encounter information to the designated utilization or peer review organization of the patient's insurer, employer, other payer, or collection agency as may be necessary to effectuate payment for the patient's care. This information may be released via electronic copy, hard copy, or fax.

_____ (initial) IV. **Guarantee of Payment/Billing Policy:** It is the parent/legal guardian's responsibility to disclose all known and potential insurance coverage sources. Peach State Pediatric Therapy Inc. will bill the patient's insurance company for rendered services as a courtesy. With this it is the patient's parent/legal guardian's responsibility to assist in the prompt receipt of payment from their insurance company. I understand that I must notify Peach State Pediatric Therapy Inc. of any changes in insurance coverage. Furthermore I understand that failure to do so will result in my responsibility for all accrued bills. I understand that I am responsible for the bill if existing insurance is terminated or service is not covered at the full rate of $160.00 per hour session and $350.00 per evaluation without exceptions.

I am aware that Peach State Pediatric Therapy Inc. may not be a participating provider with my insurance company. As a result coverage levels may be affected. I understand that it is my responsibility to contact the Member Services Representative with my plan for coverage determination. I am aware that an invoice will be given to me stating services rendered during a billing cycle and that I am responsible for paying any difference as outlined in my individual insurance plan within 30 days. Any invoice not paid in full within the 30 days will result in termination of treatment. Any invoice not paid within 90 days will be sent to a collection agency contracted with Peach State Pediatric Therapy Inc. Subsequent legal fees, collection fees, and penalties, will be added to invoice. The total of added fees may be in excess of the invoice total. I, the undersigned authorize the payment of patients medical benefits and/or government benefits as it relates to patients therapy services to Peach State Pediatric Therapy Inc.

_____ (initial) V. **Personal Valuables:** It is understood and agreed that Peach State Pediatric therapy Inc. shall not be responsible or liable for any loss, theft, misplacement, or damage of any valuables and personal belongings.

_____ (initial) VI. **Authorization to release and use photo/video:** I authorize and consent Peach State to take and use pictures/video of my child for teaching, quality improvements, research, marketing, and or presentation purposes without identifying the child.

_____ (initial) VII. **I have been provided a copy of Peach State Pediatric Therapy Inc. Privacy Policy**

_____ (initial) VIII. **Attendance/Cancellation Policy:** It is very important that you attend each and every scheduled appointment on time. Parent or legal guardian must stay on the premises for the entire length of the treatment. Therapy will be terminated if your child does not maintain a 75% attendance rate (6 out of 8 sessions or two sessions are missed without notifying the office or therapist. Cancellation must occur within 24 hours of your scheduled appointment. Do not bring your child if they are running a fever, vomiting, have diarrhea, or have an illness that is contagious (i.e. pink eye, chicken pox, etc.).

IX. I certify that I have read and understand this consent and have signed and initialed this consent in the capacity indicated below on the date indicated below.

_____ _____

Parent/Legal Guardian Signature **Date of Signature**

_____

Patient's name