



Consent and Authorization for Services and Treatment

Consent for Treatment

By signing below, this patient or legal guardian gives consent for evaluations, procedures and treatment as ordered by physician from Carolina Therapy Connection, PC and their treating therapists. With this consent, Carolina Therapy Connection, PC may e-mail or call my home or other alternative location and leave a message on voice mail or in person, in reference to any items that assist in the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items, and any calls pertaining to clinical care. This consent is valid from the date signed to the end of treatment sessions.

ACKNOWLEDGEMENT AND ASSUMPTION OF RISK

By signing below, I acknowledge and agree to have my child (or the child under my care), receive therapy services from Carolina Therapy Connection. I acknowledge that there is some risk inherent in the use of the therapy equipment during sessions and I agree to assume these risks and hold Carolina Therapy Connection and its staff, harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child or our belongings.

EMERGENCY CARE

By signing below, I grant Carolina Therapy Connection permission to seek emergency care from a hospital or physician if there is a medical emergency or medical attention is required.

Acknowledgement of Privacy Notice and Client Rights

As a client of Carolina Therapy Connection, you have certain rights regarding your child's services and the protection of your/your child's health care information. "Notice of Privacy Practices" has been given to you today. Providing your signature below means understanding that:

- 1) Any and all records, whether written, oral or electronic format, are confidential and cannot be disclosed for reasons outside of treatment or payment operations without prior without prior authorization, except otherwise prohibited by law.
- 2) A photocopy or fax of this consent is as valid as the original.

Print Client's Name	Date of Birth	Client/ Parent/Legal Guardian Signature	Date
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*Notice: This consent can be revoked at any time. Written requests can be sent to **Cindy Taylor**, Owner.
Cindy@carolinatherapyconnection.com Phone: (252)341-9944 Address: 1925-A Turnbury Dr., Greenville, NC
27858*

Attendance and Cancellation Policy

Due to the demand for services, appointments cancelled **with less than 24-hours notice** will result in a **cancellation fee of \$30**. Repeated cancellations may result in either forfeiture of permanent appointment or termination of service. Failure to contact the office prior to appointment time will be a no show and a no show fee of \$30 be charged. Cancellation fees are not reimbursed by insurance companies or Medicaid and will be billed to the responsible party. If you **miss 3 scheduled treatment sessions** without notifying the treating therapist, treatment services may be terminated.

I acknowledge that by initialing below, I have read the Attendance and Cancellation Policy, and I understand and agree to cooperate with the Cancellation Policy.

INITIALS _____

Teaching and Education of Students

Carolina Therapy Connection is a teaching facility. Students may be present and working with my child upon occasion. I give permission for occupational, physical, and speech therapy students to observe my child's therapy sessions. If I object to a student working with my child, I will not initial this section.

INITIALS _____

Insurance Policy

Prior to the first visit, Carolina Therapy Connection will verify insurance eligibility and benefits. This is a *courtesy* and the information collected is only an estimate and **does not secure payment by the insurance company**. Dependent on insurance, Carolina Therapy Connection may collect a co-pay or co-insurance at the time of visit. I understand that Carolina Therapy Connection will bill Medicaid or Insurance Company either by electronic or manual method, for services rendered through Rev-Ignition, Inc. billing agency. This patient or legal guardian agrees to authorize direct payment of insurance benefits by insurance carrier to Carolina Therapy Connection. **I understand that if my insurance carrier does not accept "assignment of benefits", I am obligated to endorse and send payments to Carolina Therapy Connection.**

INITIALS _____

Client Financial Responsibility

With this consent, Carolina Therapy Connection may verify insurance coverage for therapy services. **I understand that verification of benefits is not a guarantee of payment and I understand that if payment is not made to Carolina Therapy Connection by other payers, I will be responsible for the services rendered to my child.** This payment will be made dependent upon a written notice. I understand that I am responsible for insurance deductibles and amounts not covered by any insurance or payment provider. We require co-payments, deductibles, and non-covered charges to be paid at the **time of services**. Please be aware that some, and perhaps all, of the services provided may not be covered under your particular benefit plan. Any verbal verification of benefits or coverage is never a

guarantee of payment. **If your insurance company has not paid services in full within 30 days, the balance will automatically be billed to your account. Balances in excess of 30 days must be paid before additional services can be rendered. We also have a returned check fee of \$30 in addition to the amount of the original check.**

*****THIS DOES NOT INCLUDE MEDICAID OR INNOVATION WAIVER RECIPIENTS. MEDICAID RECIPIENTS ARE REQUIRED TO MAINTAIN ACTIVE MEDICAID STATUS, BUT CANNOT BE BALANCE BILLED FOR UNPAID CLAIMS*****

INITIALS _____

Notification of Change

This patient or legal guardian agrees to notify Carolina Therapy Connection **within 24 hours** of any information change it receives regarding changes in Insurance, Medicaid, or other funds that affect the reimbursement.

INITIALS _____

This agreement will remain in effect for the duration of treatment, and you can revoke this agreement at any time in writing, except for services that have already been provided.

Communicable Diseases

Please cancel your child's appointment if one or more of the following conditions are present:

1. Temperature of 100 degrees or higher
2. Vomiting
3. Sore throat, persistent cough, or acute cold
4. Discharging eyes
5. Skin rashes
6. Suspected scabies or impetigo
7. Head lice
8. Diarrhea

Return to therapy guidelines:

1. Fever free for 24 hours
2. Symptom free of vomiting
3. Symptom free of sore throat, persistent cough, or acute cold
4. Treated head lice
5. Symptom free diarrhea

I agree to call and cancel my child's appointment in the event that he/she presents one or more of the conditions above. I agree to call and reschedule after illness has been treated and resolved.

Print Child's Name	Date of Birth	Parent/Legal Guardian Signature	Date
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