In order to provide services to your child, we must have your consent to treat, evaluate, assess, and care for your child according to your physician’s orders, as well as to bill all applicable insurances. We also need clarification as to whether you prefer for us to bill your insurance as a courtesy, or if you prefer to manage your insurance claims and self-pay. In the case of self-pay, please leave the “consent to bill insurance” line on the second page blank. Lastly, if someone should request information relative to your child’s treatment, evaluation, assessment of therapeutic care, we need to know with whom you would authorize us to share such information on a need-to-know basis (includes family members, teachers, physicians, or others as you authorize).

**If your child is a Medicaid recipient and receives therapy services from a therapist in the Public School system, we are required to coordinate any like therapies with that therapist. We will need to obtain a copy of the school therapist’s IEP (Individualized Education Program) and coordinate our therapy schedule with theirs to ensure we do not provide the same service type on the same day.**

**Does your child receive any therapy services in the Public School System? Yes [ ]  No [ ]**

**Type(s):**

**Therapist Name(s):**

**Current school therapy schedule(s):**

**I HEREBY GIVE RIGHTS TO MY CHILD’S RECORDS TO THE FOLLOWING INDIVIDUALS, PRACTICES, AND ORGANIZATIONS UPON REQUEST**:

 **\* Check here for ANY AND ALL** **[ ]  and initial** **and skip forward to next boxed segment**

SERVICE COORDINATOR       (enter practice or name)     (initial)

PRIMARY CARE PHYSICIAN       (enter practice or name)     (initial)

ADDITIONAL PHYSICIANS       (enter practice or name)     (initial)

SCHOOL SYSTEM       (enter County & School name)     (initial)

INDIVIDUALS       (enter names)     (initial)

OTHER           (initial)

**I DO NOT WISH TO SHARE MEDICAL OR PERSONAL INFORMATION WITH THE FOLLOWING INDIVIDUALS, COMPANIES, ORGANIZATIONS, ETC.:**

**INITIAL TO SIGNIFY CONSENT TO TREAT**

**INITIAL TO SIGNIFY CONSENT TO BILL INSURANCE(s)**

**INITIAL TO SIGNIFY RECEIPT OF HIPAA INFORMATION**

**INITIAL TO SIGNIFY RECEIPT OF SCHEDULING POLICY**

**INITIAL TO SIGNIFY RECEIPT OF WRITTEN / ORAL PATIENT RIGHTS INFORMATION**

**INITIAL TO SIGNIFY RECEIPT OF DISCHARGE OR TRANSFER POLICY**

***If you have any questions or concerns regarding any of the information provided, please contact us at the phone number on this form.***

**Parent/ Legal Guardian Signature:**

**Date:**