CONSENT and ADMISSION AGREEMENT

CONSENT AND RELEASE OF INFORMATION:

I consent to the provision of services and do authorize the staff of Kid Physical, LLC to provide in home services as noted in my Plan of Care. I authorize release of information regarding my treatment including inpatient stays, testing and results and payment information to be released from my physician and/or any treatment facility to Kid Physical, LLC under HIPAA guidelines.

FINANCIAL RESPONSIBILITY: (AGENCY STAFF TO MARK BOX AND PATIENT TO INITIAL)

☐_____ I understand that charges for my services are:

Service: Physical Therapy Rate $240/visit Frequency _____

Service: Occupational Therapy Rate $240/visit Frequency _____

Service: Speech Therapy Rate $240/visit Frequency _____

☐_____ I understand that I am ultimately responsible for payment of charges for services I receive from this agency including those covered by my insurance. As a convenience, this agency will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine. In addition, I am responsible for notifying this agency of any insurance changes.

I also understand the following: (AGENCY STAFF TO NOTE WHICH PAYOR APPLIES. CLIENT TO INITIAL UNDERSTANDING.)

☐_____ All my care will be paid for by Medicaid. I certify that I understand it is my responsibility to inform Kid Physical, LLC if I choose to participate in an HMO or if my Medicaid status changes. I authorize release of all records required to act on this request. I request that payment of benefits be made on my behalf.

☐_____ All my care will be paid for by my CCB. I certify that I understand it is my responsibility to inform Kid Physical, LLC if my insurance changes. I authorize release of all records required to act on this request. I request that payment of benefits be made on my behalf.

☐_____ Kid Physical, LLC will bill my insurance. I understand that I am responsible for any portion of my bill that my insurance does not pay. I understand my current co-pay is _____ and my deductible is _____. I request that payment of benefits be made on my behalf.

☐_____ I am responsible for paying my bill within 30 days of the invoice/statement date. I understand that I may be charged 18% interest for any portion of my bill unpaid for more than 60 days.

PARENT PRESENCE:

_____I understand that health and wellness require an alliance between parents and therapists and most therapy sessions include demonstrations of techniques to parents so that they can follow through with observed and recommended activities. I will do my best to find a time for therapy when I can be present.

_____ For the times that neither parent/guardian are able to attend therapy sessions with my child, I give permission for

_____ to attend and for Kid Physical, LLC therapists to share any relevant medical information necessary to provide service and instruct my representative in the home exercise program.

ADVANCE DIRECTIVES:

☐ Client has not made any advance directive and has no Medical Power of Attorney.

☐ Client has made advance directives, location _____

☐ Client has Medical Power of Attorney _____

ph # _____ location _____

☐ Client has Do Not Resuscitate order, location _____

_____ I agree to provide a copy of all my Advance Directives and Medical Power of Attorney authorizations, and I understand that if I make any new or different decisions, I will notify Kid Physical, LLC.

CONSENT and ADMISSION AGREEMENT

USE OF EMAIL: **EMAIL ADDRESS:** _____

_____I consent to the use of email. I understand that Kid Physical, LLC will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the inherent risks, Kid Physical, LLC cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure of confidential information that is not cause by Kid Physical, LLC's intentional misconduct.

ILLNESS, CANCELLATION, AND NO-SHOW POLICY:

_____ If your child or someone in your home is sick, please contact us as soon as possible to discuss with your therapist whether it may be best to reschedule your appointment. Our therapists will afford you the same consideration. We need to be mindful of the health and safety of our staff and all of the kids on our caseload, including yours. If you need to cancel or reschedule an appointment, please notify our office at least 24 hours in advance. You can reach us by phone or email. Excessive cancellations may result in forfeiting your recurring spot. If you do not show up for your scheduled appointment without prior notice more than once in a 6-month period, you may be removed from our caseload. We understand that emergencies and unexpected situations can arise, resulting in last-minute cancellations or no-shows. If this occurs, please contact our office as soon as possible to discuss the situation and any possible exceptions. We want to help your family make progress toward your goals and in order to do that we need to see you consistently.

COORDINATION OF CARE:

_____ I understand Kid Physical must coordinate with all companies providing healthcare services in my home and I agree to share this information with Kid Physical.

☐ Children's Hospital

☐ Dr(s) _____

☐ Therapists _____

EI Broker: ☐ The Resource Exchange ☐ Developmental Pathways ☐ Rocky Mountain Human Services

☐ Public School District (Specify) _____

☐ Other (Specify) _____

_____ I refuse to share this information, and do not wish Kid Physical to coordinate with other providers.

INFORMATION RECEIVED:

_____I have received the following and had the opportunity to have my questions answered regarding: Written Consumer Rights & Responsibilities; Agency Disclosure Notice; Advance Directives information and agency policy; Emergency Preparedness Training, Notice of Privacy Rights.

AGREED UPON DAYS AND TIMES: _____

Client Name: _____

_____ _____ _____/ _____

Signature Client/Responsible Party Date Printed Name of Responsible Party/ Relationship

_____ _____

Signature Kid Physical, LLC Representative Date