Client Information/Guarantee of Payment

Child's Name _____ Age _____ Date of Birth _____

****

Mother's Name _____ Social Security #_____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cellular Phone _____

Email _____

Employer's Name _____

Employer's Address _____

****

Father's Name _____ Social Security #_____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cellular Phone _____

Email _____

Employer's Name _____

Employer's Address _____

****

Emergency Contacts (if parent/guardian can't be reached)

Name _____ Phone 1 _____

Relationship _____ Phone 2 _____

Parent/Guardian Authorization:

I _____, Parent/Guardian of _____, give permission for my child to receive an evaluation and/or therapy services provided by Children's Therapy Place, Inc. In addition, I agree to pay for services provided by Children's Therapy Place, Inc. Additional services requested that I request (i.e. attendance at IEP meetings, additional file review/documentation, etc.) will be billed at an hourly rate, based on the current fee schedule. Payment for services are due at time of visit, unless other arrangements have been made. There will be a $35 charge on all returned checks. A monthly interest charge of 1.5% is applied to patient balances greater than 30 days.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/Guardian Signature Date

INSURANCE INFORMATION AND AUTHORIZATION FOR PAYMENT

Insured's Name _____

Name of Insurance _____

Insurance ID Number _____

Insured's Date of Birth _____

Insured's Policy Group or FECA Number _____

Employer's Name or School Name _____

Insurance Plan Name or Program Name _____

**** Please submit a copy of your insurance and/or Medicaid card(s) ****

Is there another health benefit plan? _____ Yes _____ No

Secondary Plan of Insurance _____

Insured's Name _____

Insurance ID Number _____

Insured's Date of Birth _____

Insured's Policy Group or FECA Number _____

Employer's Name or School Name _____

Insurance Plan Name or Program Name _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to Children's Therapy Place for therapy services received.

SIGNED _____

PHYSICIAN CONTACT INFORMATION

Name of Physician _____Phone # _____

Group _____

Children's Therapy Place Inc.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Operations.

I, _____, the parent/guardian of _____ understand that as part of my child's services, CTP originates and maintains paper and/or electronic records describing my child's service history. I understand that this information serves as:

- A basis for evaluation and therapy treatment,
- A means of communication among the many health professionals who contribute to my care,
- A tool for assessing quality and reviewing the competence of therapists.

I am aware that CTP has a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I may request a copy of the Notice if I so desire. I also understand that I have the following rights and privileges:

- The right to review of the notice prior to signing this consent,
- The right to object to the use of my child's information for directory purposes, and
- The right to request restrictions as to how my child's information may be used or disclosed to carry out treatment, payment, or therapy operations.

I understand that CTP is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that CTP reserves the right to change its notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I may request a revised Notice of Privacy Practices at any time by calling the office and requesting a copy or by asking for a copy at my next visit.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that as part of this organization's treatment, sessions may be conducted in a group environment and as such may be observed by a third party. Notice will be given prior to your child's appointment if observation is to occur by a student and/or intern.

_____No I do not want a copy of the Privacy Rule

_____ Yes I would like a copy of the Privacy Rule

I fully understand and accept the terms of this consent.

_____ _____

Parent/Guardian's Signature Date

Children's Therapy Place Inc.

AUTHORIZATION FOR DISCLOSURE

Client Information

Client Name_____ Date of Birth_____

Mailing Address_____State_____Zip Code_____

Requestor Information to be completed if authorization is being made by someone other than the subject of the information.

Requestor Name_____Children's Therapy Place, Inc._____Telephone (208) 323-8888____

Relationship____Therapy Provider_____

Address___6855 W Fairview Avenue, Boise_____State__ID_____Zip Code __83704__

Authorization Details

I authorize the following_____

To disclose this confidential information to_____Children's Therapy Place, Inc._____

Address__6855 W Fairview Avenue, Boise_____State__ID___Zip Code__83704____

Fax____(208) 323-8889_____Phone___(208) 323-8888_____

For the purpose of_____Therapy_____

Please describe in detail the information to be disclosed

_____

_____

_____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization.

_____

Signature Date

Children's Therapy Place Inc.

CREDIT CARD AUTHORIZATION

CTP offers the convenience of leaving a credit card on file to handle all co-payments and any applicable fees regarding your therapy. If you would like to utilize your credit card as a consistent form of payment, please fill out the section below and return it to the billing department. Thank you!

I authorize Children's Therapy Place, Inc. to keep my signature on file and to charge my account for balance of charges not paid by insurance, Medicaid and/or Katie Beckett within 60 days and not to exceed $_____.

I understand that my credit card will be charged $25 for any missed appointments or cancellations with less than a 24-hour notification.

I understand this form is valid for one year unless I choose to cancel the authorization through written notice to Children's Therapy Place, Inc.

Circle One: Visa Mastercard Discover

Client's Name _____

Cardholder's Name _____

Cardholder's Signature _____

Statement Address _____

Cardholder's Email Address _____

Credit Card # _____

Expiration Date _____

Security # (from back of card) _____

Banking Institution _____

Children's Therapy Place Inc.

We want to take your picture! This form is optional. It is a request, not a requirement.

- Your picture may also be used to promote services through posters, flyers, brochures, etc. We feel the best way to do that is to present snapshots of real clients participating in the therapy process.

CONSENT TO PHOTOGRAPH/VIDEOTAPE

I, the parent/guardian of _____ hereby give Children's Therapy Place, Inc., its agents, and/or assignees permission to use the photographs, motion pictures or any reproductions of my child's physical likeness taken of him/her in any manner it deems proper. I further allow Children's Therapy Place, Inc. to use my child's first name in Facebook postings, blogs, and other social media, etc. I relinquish all rights, title, and interest I may have in the finished pictures, negatives and copies. I waive the right of prior approval and hereby release Children's Therapy Place, Inc., its agents, and/or assignees from any and all claims from damages of any and all kinds based on use of said material. I am of legal age and freely sign this release, which I have read and understand.

_____

Signature Date