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 _____ Please circle for text and/or email reminders YES NO

Employer's Name _____

Employer's Address _____

****

Father's Name _____ Social Security #_____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cellular Phone _____

Email _____ Please circle for text and/or email reminders YES NO

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 _____ Telephone _____

Relationship _____

Address _____State_____Zip Code_____

Authorization Details

I hereby authorize Children's Therapy Place, Inc. and any of their employees, agents, or associated health care providers to exchange and disclose confidential information with-

Name **and** Organization_____

Address_____State_____Zip Code_____

Phone _____ Fax _____

For the purpose of therapeutic treatment coordination and health care billing operations.

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 also 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.

Unless revoked sooner, this authorization **expires one year** from signed date.

_____

Signature Date

Attendance Policy and Contract

Dear Children's Therapy Place Families,

At Children's Therapy Place we aim to provide the most compassionate, comprehensive care for your children. We pride ourselves on the dynamic and integrative services offered at our Treasure Valley and Magic Valley locations.

We also value your commitment to your children's services both at home and in our clinics. Maintaining your child's attendance to therapy sessions is vital to their ability to achieve their goals and make progress. In consideration of this, please take a moment to review our attendance policy.

Children's Therapy Place would like every client to maintain 90% or better attendance to their scheduled therapy appointments. If you need to cancel or reschedule an appointment for your child, please observe our 24-hour cancellation policy and contact our offices at 208.323.8888.

- A missed scheduled appointment without a notice of cancellation 24 hours prior will result in a phone call from your child's provider to reschedule the missed appointment.
- A second missed appointment without 24 hours prior notice, will result in a phone call from the Office Coordinator to ensure your child's appointment time best accommodates your schedule.
- If there is a third missed appointment without 24-hour prior notice, your child will be discharged from regular services at Children's Therapy Place. A formal Discontinuation of Services Letter will be mailed to you to inform you that if you wish to re-establish services, your child will be placed on a waitlist pending your confirmation of a consistent schedule.
- If your child falls below our minimum standard percentage for attendance, they may be referred for attendance counseling.

For your convenience, we offer appointment reminder calls and emails. To add your family to the appointment reminder call list, please contact our receptionists.
We understand that extenuating life and health circumstances can make meeting our attendance policy difficult, which is why communication with our staff is crucial. We will use discretion in determining both the nature, and frequency of absences when enforcing our attendance policy.

Thank you for your cooperation.

Respectfully,

Children's Therapy Place.

By signing below, I confirm that I have read and understand the Children's Therapy Place attendance policy and agree to its terms.

_____ _____

Patient Name (Printed) Date of Birth

_____ _____

Parent/Legal Guardian Signature Date

CTP
children's therapy place

Teletherapy Informed Consent Form

(1) "Teletherapy" includes consultation, treatment, emails, telephone conversations, and other medical information using interactive audio, video, or data communications.

(2) Teletherapy occurs in the state of ID (USA), and is governed by the laws of that state.

(3) The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless agreed upon, or necessary for treatment.

(4) I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

(5) In the event our teletherapy is not in my best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

(6) I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

I have read, understand, and agree to the information above.

_____
Client's Name

_____ _____
Signature of Client (or Legal Guardian if under age 18) Date

CTP
children's therapy place

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other_____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____ CVV Code _____

Cardholder ZIP Code (from credit card billing address): _____

Copay/Coinsurance amount $_____

I, _____, authorize Children's Therapy Place, to charge my credit card above for agreed upon copays, deductibles, etc, as applicable. I understand that my information will be saved to file for future transactions on my account and recurring charges will occur based on therapy services received.

I have read, understand, and agree to the information above.

_____
Client's Name

_____ _____
Signature of Cardholder Date

CHILDREN'S THERAPY PLACE, INC.
BOISE ---- MERIDIAN --- NAMPA --- TWIN FALLS
PH (208) 323-8888 FAX (208) 323-8889 PH (208) 423-8957 TWIN FALLS
WWW.CHILDRENSTHERAPYPLACE.COM