AUTHORIZATION FOR BILLING AND CONSENT TO TREAT

Child's Name _____ DOB:_____

I authorize ProActive Pediatric Therapy, LLC or any entity doing business with ProActive Pediatric Therapy, LLC to verify the benefits of our insurance and email us the benefit details. **Initial____**

I authorize ProActive Pediatric Therapy, LLC to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to ProActive Pediatric Therapy, LLC.
I authorize ProActive Pediatric Therapy, LLC to release medical or other information necessary to process this claim.
I understand that the verified estimation of benefits is provided as a courtesy and does not guarantee coverage. I realize that I am ultimately responsible to know my level of coverage.
I authorize to release medical or other information Proactive Pediatric Therapy necessary to process this claim.

Initial_____

ProActive Pediatric Therapy, LLC will submit claims to my health insurance company. I am responsible for payment of my deductible, co-insurance or co-payment, and any charges not reimbursed by my insurance carrier(s).

Initial_____

It is my responsibility to inform ProActive Pediatric Therapy, LLC of any and all changes of insurance coverage during the course of treatment. Failure to do so may result in denial of coverage by my insurance company. If my insurance changes, ProActive Pediatric Therapy, LLC will bill my new insurance company, but there is no guarantee they will cover the services.

Initial_____

ProActive Pediatric Therapy, LLC uses a billing company to process claims and payments. The billing company is of our choice and its employees will have access to protected patient information. This is for the purposes of providing insurance companies with needed information to process claims. Your initials indicate your permission to share protected patient information in order to process payments on your child's behalf.

Initial_____

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient as ProActive Pediatric Therapy, LLC.

Initial_____

I hereby release, discharge and acquit ProActive Pediatric Therapy, LLC , it's agents, representatives, affiliates, employees or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

Initial_____

Notice of Privacy Policy This notice tells you how we collect, handle, and disclose personal health information. If you want to limit our disclosing, please submit your wishes to us in writing. We protect personal health information we collect by maintaining physical, electronic, and procedural safeguards that meet applicable laws. The Protected Heath information we collect about your comes from the following sources: Information received from your physician or other health care providers, from you while providing therapy services, on enrollment forms, assessments, evaluation, or other forms, from other caregivers, insurer, employer or other. We may disclose any of your protected health information to the following entities as long as this information directly relates to health services, we provide for you or your child's individual care. These entities may include doctor, billing services, your insurance company, or other caregivers that bring your child to therapy.

AUTHORIZATIONS AND ACKNOWLEDGEMENTS

1. I have received the Notice of Privacy Practices from ProActive Pediatric Therapy, LLC.

2. I have received the Patient Service Agreement from ProActive Pediatric Therapy, LLC.

SIGNATURE: X _____ DATE: _____

(Parent/Legal Guardian)

AUTHORIZATION TO BILL INSURANCE

All commercial insurance and private pay clients (excludes Medicaid):

To streamline our billing process and to more efficiently collect payments, we are mandating a credit card on file to process all patient related balances. All deductibles, co-insurances, co-payments, missed appointment fees, and all other non-covered services will be auto-charged to the credit card on file. A receipt will be emailed to the email address on file. Upon request, an itemized summary report will be

mailed showing how the payments have been applied towards the balance. A $20 processing fee will be applied to all declined credit cards so it will be imperative to keep an updated card on file.

If you have any questions about this policy please contact Julie Frazier, Billing Administrator at (316) 263-0776 or juliefrazier@medisourcehcs.com

PAYMENT AUTHORIZATION FORM

Required for all non-Medicaid Clients

Please note: If you do NOT have Medicaid, we must have at least 1 credit card on file before we will begin services.

Please contact Julie Frazier, Billing Administrator at (316) 263-0776 to place a credit card on file that may be used to pay remaining balances or copays. Services will not begin until an authorized payment is on file.

I have read and agree to abide by the above policies and am aware of the privacy policy. I agree to the Payment Policy/Assignment of Benefits/Authorization to Release Medical Information.

Initial_____

By signing, I agree to have Medisource Healthcare Solutions bill my insurance and/or process my credit card after each visit on behalf of (when applicable for non-Medicaid clients).

Initial_____

AUTHORIZATION FOR OTHER CARE PROVIDERS TO RECEIVE INFORMATION

OTHER CONTACTS

Please list other individuals who are involved in taking care of the patient, such as caregiver and/or relative other than guardian, with whom you authorize ProActive Pediatric Therapy, LLC to discuss/exchange information regarding the patient's treatment.

NAME: _____

RELATION TO PATIENT:

_____

HOME PHONE: _____-Cell _____

NAME: _____
RELATION TO PATIENT:
_____

HOME PHONE: _____ CELL PHONE: _____

AGREEMENT TO RECEIVE ELECTRONIC INFORMATION

I agree that ProActive Pediatric Therapy, LLC may communicate with me electronically at the email address and/or cell phone number listed below.

Note: ProActive Pediatric Therapy, LLC values your privacy and will provide encryption of Personal Health Information (PHI) when communicating with you via email.

I am aware that there is some level of risk that third parties might be able to read emails or text messages.

I am responsible for providing ProActive Pediatric Therapy, LLC any updates to my email address and cell phone number.

I can withdraw my consent to electronic communications by calling: 319.200.2004

Please indicate below how we may share protected health information with you. Initial or check all that apply:

 Home voice mail/machine

 Via texts to my cell phone

 My cell phone voice mail

 My work voice mail

 Via my email address

Email address & Cell Phone (PLEASE PRINT CLEARLY):

_____@_____Cell #_____

SIGNATURE: X _____ DATE: _____
(Parent/Legal Guardian)