CONSENT FOR RELEASE OF INFORMATION

_____, give permission for Pediatric
Parent or legal guardian's name
Therapy Network® to exchange information on child _____. By signing this form, I understand that Pediatric Therapy Network may contact the persons or agencies (i.e. physician, other therapy agencies, school programs, etc.) listed below to obtain more information on my child, such as reports or evaluations. In addition, Pediatric Therapy Network may contact and send copies of goals, reports and other pertinent information to the agencies/individuals listed below.

Agency/Name: _____

Address: _____

Telephone: _____ Date:_____

Agency/Name: _____

Address: _____

Telephone: _____ Date:_____

Agency/Name: _____

Address: _____

Telephone: _____ Date:_____

_____ _____
Parent or Legal Guardian Signature Date

_____
Printed Name

PEDIATRIC THERAPY NETWORK (PTN) CONSENT FOR TREATMENT OF A MINOR, BILLING, ATTENDANCE AND MAKE-UP POLICY, and PARTICIPATION IN TREATMENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Signed consents on the following two pages are mandatory prior to beginning therapy at PTN

Child's name:_____ Parent/Guardian's name:_____

CONSENT FOR TREATMENT OF A MINOR

As parent and/or legal guardian, I authorize Pediatric Therapy Network to treat and/or evaluate my child.

_____ _____

Signature of parent or guardian Date

CONSENT FOR BILLING

I understand that I am responsible for all charges incurred for therapy services provided for my child, regardless of insurance coverage. I understand that Pediatric Therapy Network bills my personal insurance carrier as a courtesy and that I am responsible for the bill. I am responsible for keeping Pediatric Therapy Network up to date on any changes to my plan or policy. I understand that if my insurance carrier does not remit payment to Pediatric Therapy Network within 60 days, the balance owed will be due in full from me.

_____ _____

Signature of parent or guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices (Notice). The Notice describes, in accordance with the HIPAA Privacy Regulations, how PTN may use and disclose my child's protected health information to carry out treatment, payment or health care operations and for the other specific purposes that are permitted or required by law. The Notice also describes my rights and PTN's duties with respect to protected health information about my child.

_____ _____

Signature of parent or guardian Date

CONSENT FOR ADHERING TO PTN ATTENDANCE AND MAKE-UP POLICIES

The enclosed documents on PTN's illness, attendance and make-up policies outline many important guidelines for successful participation in therapy programs. I verify that I have read these policies and agree to abide by them.

_____ _____

Signature of parent or guardian Date

CONSENT FOR PARTICIPATION WITH THERAPEUTIC EQUIPMENT

Intervention programs at PTN usually involve the use of specialized equipment such as suspended equipment and various swings, bolsters, inflated therapy balls, climbing structures, hanging bars, tactile media (such as soap foam, Play-Doh and lotion), and a variety of other activities that involve fine, gross and oral motor coordination. Therapy activities often involve encouraging the child to try new things in ways that are challenging in order to foster increased skills and abilities. While PTN staff make great efforts to ensure each child's safety, the nature of the therapeutic intervention includes the risk of falling, bumping into other people/equipment. I am aware of the inherent risk of this type of activity, and I give permission for my child to participate in therapy as described.

_____ _____

Signature of parent or guardian Date

PEDIATRIC THERAPY NETWORK (PTN) CONSENT FOR EMERGENCY MEDICAL TREATMENT, VIDEOTAPING, PHOTOGRAPHING, AND REVIEW OF RECORDS

Child's name:_____ Parent/Guardian's name:_____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In case of emergency and if I am not present and cannot be contacted at the telephone numbers on my child's parent information form, I understand that in the event of a medical emergency, PTN will call 911 or other appropriate medical personnel. If an ambulance must transport my child, I understand that it will take my child to the closest medical facility available. I give permission to the personnel of PTN to consent to any x-ray examination, anesthesia, medical or surgical treatment and/or other emergency medical care advised by a licensed physician or dentist and rendered under the provisions of the Medical or Dental Practice Act. I understand that PTN will not be liable for any first aid treatment, medical or hospital care, medications or surgical procedures rendered pursuant to this consent.

_____ _____
Signature of parent or guardian Date

CONSENT FOR VIDEOTAPING & PHOTOGRAPHING FOR USE AT PTN

Therapists often videotape or photograph children who receive therapy services at PTN to help monitor and document a child's areas of concern, as well as progress. Videotapes and photos are used and reviewed only by PTN staff. Parents are welcome to view their child's videotape at PTN.

I do____ do not____give consent for my child to be videotaped and/or photographed as part of his/her therapy program for use by PTN staff only.

_____ _____
Signature of parent or guardian Date

CONSENT FOR VIDEOTAPING & PHOTOGRAPHING FOR EDUCATIONAL & PUBLIC AWARENESS PURPOSES

Staff at PTN are frequently asked to teach at courses, seminars or workshops nationally and internationally as well as to write books, chapters, newsletter/newspaper articles and televised stories. We often like to include videotape, slides or photos during our presentations.

I do___ do not___ give permission for my child to be videotaped/photographed for educational and public relations purposes. If photographed or videotaped, neither I, nor my child, will seek any financial reimbursement for the use of these images. I understand that my child's name and any identifying information, will not be used in association with these images.

_____ _____
Signature of parent or guardian Date

CONSENT FOR REVIEW OF RECORDS

Research is an important part of the mission of PTN and our staff are frequently involved in various research projects. Review of records can often be an important part of research. For example, comparing test scores among children who have different diagnoses might help a researcher know how to plan more appropriate intervention plans for different diagnoses. When this occurs, all names, addresses, phone numbers and other identifying information are kept strictly confidential. Giving permission for record review does not give permission for the use of any procedure or involvement in activities outside the typical therapeutic intervention program a child receives. Participation in research outside of regular therapeutic intervention requires specific written consent in advance of participation and review by a board that ensures the safety of such procedures for the subjects.

I understand these parameters and I do___ do not___ give permission for my child's records at PTN to be reviewed for research purposes.

_____ _____
Signature of parent or guardian