Therapies 4 Kids
Exceptional Care For Exceptional Children

CONSENT, PERMISSION AND RELEASE FOR USE OF PHOTO, VIDEO AND / OR AUDIO

I hereby give consent and permission to Therapies 4 Kids, Inc. to record the appearance and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of

_____ (print name), age _____ (if minor).

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statues, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by Therapies 4 Kids, Inc. and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that Therapies 4 Kids, Inc. is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that is has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video, and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

Therapies 4 Kids, Inc. has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold Therapies 4 Kids, Inc., its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone number: _____ E-mail address: _____

Date: ___ / ___ / _____ Signature: _____

Required if subject is under age 18:

Name of parent / legal custodian: _____

Signature of parent / legal custodian: _____

Witness name: _____

Witness signature: _____ Date: ___ / ___ / _____

☐ **I am revoking this consent.**

I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold Therapies 4 Kids, Inc. responsible for instances of these violations.

Signature: _____ Date: ___ / ___ / _____

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PAYMENT POLICY

It is our policy that payments are due at the time of service. If we are contracted with your insurance company, we will file your insurance. However, you are responsible for all co-pays, deductibles and non-covered services at the time of service. If we are not contracted with your insurance company, payment will be due at the time of service. We will file your insurance claim as a courtesy so you may be reimbursed as per your policy.

I understand and agree regardless of my insurance status, I am ultimately financially responsible for services provided by Therapies 4 Kids, Inc.. I certify that the information I have supplied about myself / dependent and insurance coverage are true and accurate to the best of my knowledge. I will notify Therapies 4 Kids, Inc.'s office with any changes in this information.

☐ Your primary health insurance carrier has verified that you have a $_____ yearly deductible of which $_____ has been met. After your deductible has been satisfied, your insurance carrier covers therapeutic benefits at _____%. You have the responsibility of $_____ or _____% co-payment due at each visit. Your insurance carrier has advised us that your policy has the following limitations:

_____

Signature: _____ Date: ___ / ___ / _____

☐ Your primary health insurance carrier has verified that your poilcy does not cover therapeutic benefits. We have agreed that you will pay $_____ for the evaluation and $_____ for each session, due at the time of service.

Signature: _____ Date: ___ / ___ / _____

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PAYMENT RESPONSIBILITY WHEN CHECKS ARE SENT DIRECTLY TO PATIENT

Please be advised that your insurance company may automatically send payments directly to your home for services rendered by our office. It is your responsibility to forward these payments to our office as soon as possible so that we may properly credit your account. If your check is made payable to you directly, please deposit that check in your account and give us a personal check or money order for the amount you were paid, along with a copy of the check and the explanation of benefits your insurance company sent to you. If we do not receive these payments within fifteen (15) days, your account will be referred to our Collection Department. Thank you in advance for your cooperation.

I have read the above statement and agree to comply with Therapies 4 Kids, Inc. office policy.

Name: _____ Signature: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Therapies 4 Kids, Inc. for medical benefits, if any, otherwise payable to me under the terms of my insurance policy.

Name: _____ Signature: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Therapies 4 Kids, Inc. to furnish my insurance companies, hospital, referring consulting physicians and billing agents all information with regard to my medical care.

Name: _____ Signature: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Therapies 4 Kids, Inc. Notice of Privacy Practices. The notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Therapies 4 Kids, Inc. operations. The notice also describes my rights and Therapies 4 Kids, Inc. obligation to respect my protected health information. The Notice of Privacy Practices is also posted at the front desk of the office.

Therapies 4 Kids, Inc. can change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Name: _____ Signature: _____

CANCELLATION POLICY

All Part C, Medicaid, private insurance, and private clientele will be charged a $25 cancellation fee for last minute cancellations. Cancellations must be made with 24 hours' notice, no exceptions!

I have read and agree to abide by the above policy.

Name: _____ Signature: _____