Caregiver's Name (Completing the Form): _____ **Child's Name:** _____

Caregiver's Phone Number: _____ **Child's DOB:** _____

I authorize Playworks Therapy ("Playworks") to share information about my child with the following healthcare providers or individuals:

_____

_____

_____

_____

I also grant permission for Playworks to conduct evaluations, treatment, and consultative services for the mentioned client either through teletherapy or at the clinic. During my child's sessions, I will either be present on-site or available at the phone number listed above.

Consent for Rates

Assessments
The assessment rates are charged at a flat rate, covering both the in-person evaluation time and the additional time spent scoring assessments, drafting reports, and reviewing findings with parents.

Rate	Assessment
$340	Speech/Language Therapy
$750	Occupational Therapy
$750	Feeding
$370	Oral Motor/Swallowing
Physical Therapy Assessment costs change based on tests and evaluations used, specifically priced at $185, $370, and $555	

Treatment
The listed rates for services are based on a 50-minute session. For sessions shorter than 50 minutes (25 or 40 minutes), the rate will be prorated according to the actual session time.

Rate	Service
$170	Speech/Language Therapy
$125	Social Group
$170	Reading Therapy (Orton-Gillingham)
$175	Occupational Therapy
$185	Physical Therapy
$185	Feeding Therapy

Reports, treatment plans, progress notes, parent meetings, and assessments are charged at the same hourly rate. All co-treatments will be billed at the rates of both clinicians involved.

I acknowledge that I am responsible for full payment for all charges incurred for services rendered to the patient according to the rates specified in this document, which includes the agreed upon cancellation policy. In the absence of a provided credit card number, payment is due at the time of service. I understand that matters relating to health insurance, including policies and reimbursements, are solely between myself and my health insurance company. Playworks will directly bill me for all services rendered to the specified individual.

Consent to Policies

Release of Liability and Assumption of Risk

I understand and agree that participation in therapeutic activities carries certain inherent risks of personal injury.

In consideration of the services provided, I knowingly and voluntarily release, waive, and discharge provider, it's owners, employees, agents, and representatives from any and all claims, demands, liabilities, damages, actions, or causes of action arising out of or related to any personal injury, loss, or damage that may be sustained by the patient while participating in or receiving services, or within provider's facilities.

Acknowledgement of Receipt of HIPPA Privacy Practices

I acknowledges receipt of a copy of Provider's "Notice of Privacy Practices," which explains how the Patient's protected health information may be used and disclosed pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I understand that Provider will maintain confidentiality of such PHI, however, Guardian consents to Provider's release of medical information for conditions or diagnoses regulated by federal statute, and permits such release of medical billing data related to claims.

Cancellation Policy

I acknowledge that appointments canceled with less than a 24-hour notice will be charged the half of the service rate, excluding emergency situations or illness.

Late Pickup Policy

I acknowledge that any pickup later than the agreed to pickup time will be considered a late pickup, and may incur a fee of 25 dollars.

Attendance Policy

Maintaining a consistent time on your therapist's schedule is contingent upon adhering to our attendance policy.

The policy mandates a minimum attendance rate of 75%, equivalent to attending 3 out of 4 sessions or 6 out of 8 sessions, depending on the frequency of your monthly appointments. Please note that clinic-canceled sessions will not be considered missed appointments. In the event of missed sessions, your child's therapist will collaborate with you to arrange makeup sessions, facilitating the maintenance of the 75% attendance rate. Playworks reserves the right to charge for 75% of scheduled sessions and/or forfeit your consistent time slot if the attendance policy is not met.

Group Attendance Policy

For group sessions with two or more clients: If other group members cancel and only my child remains, I understand that I will be charged the 1:1 therapy rate instead of the group rate. I will not be charged or penalized for canceling the session last minute if the other group member cancels and I choose not to attend.

Consent for Billing (Tricare ONLY)

I understand that all services covered by Tricare, Humana, will be billed directly to Humana. I am responsible for services NOT COVERED by Tricare and all co-pays. I understand it is my responsibility to maintain an active referral, and agree to renew the referral for Playworks through my child's primary physician every 365 days and/or as required per my physician and/or Tricare, Humana. In addition, I agree to notify Playworks immediately of any change in status to my military insurance policy (specifically should the policy shift from Tricare Prime to Tricare Select, or Tricare Select to Tricare Prime). I understand such shifts require different types of referrals and I agree that services may need to be paused until appropriate referrals per policy have been successfully approved. I also understand that without proper notification of my insurance policy change to Playworks, I am responsible for any amount not covered by Tricare, Humana should services continue under the improper referral order.

Sponsor's Name: _____ **Sponsor's Social Security Number:** _____

If the social security number is not provided, Tricare will not be charged directly, and therefore I will be responsible for all charges.

Authorization to Disclose Information to Insurer: I understand and agree that by executing this Agreement, Provider is expressly authorized to release and disclose any and all of the Patient's protected health information (PHI), including, but not limited to diagnoses, treatment notes, session dates, medical billing data related to claims, and progress reports, to the disclosed insurance company and its agents.

The foregoing authorization is for the express purpose of processing insurance claims, determining benefits, performing utilization reviews, and securing payment for Services rendered. This authorization shall remain in effect for as long as the Patient receives Services from Provider, unless revoked in writing by the Guardian.

Consent for Social Media

I give permission for Playworks staff to use my child's image in marketing materials such as social media posts and website updates

: _____

Consent for Community Outings

I give permission for Playworks staff to provide therapy services in the local community (i.e. Woodstock playground, Starbucks, CVS, etc.)

: _____

Signature: _____
Date: _____