Playworks

Speech, Language and Occupational Therapy

Consent for Services

I, _____, give permission to Playworks Speech, Language and Occupational Therapy ("Playworks"), to exchange information with the following physicians, programs, or other persons:

_____

_____

about _____, whose date of birth is

_____.

I also give permission for Playworks to provide evaluations, treatment, and consultative services to the above- mentioned client via teletherapy, in the clinic, or in a backyard setting (as indicated). I understand that Playworks staff is complying with recommended guidelines from the Center for Disease Control and the World Health organization as well as the Public Health Department in Arlington County. Despite the presence of new Personal Protective Equipment and the enactment of new sanitation protocols, I acknowledge that there is inherent risk of contracting covid-19 as a result of participating in a backyard or clinic visit.

While my child is receiving services, I will remain on the premises at all times.

I acknowledge that the backyard visits will be conducted on uneven terrain and I acknowledge there is risk involved while using the equipment in the backyard.

I understand that Playworks will not share information regarding the above- mentioned client with any individuals not listed on this form and all medical records, treatment notes, and other individually identifiable health information will be kept properly confidential.

Fees

I understand that Playworks fees are as follows:

- 50 minutes of speech/language therapy is $150.00
- 50 minutes of occupational therapy is $155.00
- 50 minutes of physical therapy is $165.00

I also understand that I will be charged at the time of service. **Reports, treatment plans, progress notes, and assessments are charged at the same hourly rate**. I understand that if I do not provide a credit card number, payment is due at the time of service.

I understand that health insurance policies and reimbursement are between myself and my health insurance company, that all services rendered by Playworks, for the benefit of the above referenced individual are charged directly to me, and that I am personally responsible for payment, in full, to Playworks within ten days of the invoice date.

In light of the current pandemic, speech therapists and occupational therapists will be using zoom for healthcare providers to provide HIPPA compliant teletherapy. I will help Playworks therapists safeguard the privacy of all clients in our community by keeping information shared during the zoom conferences confidential.

Cancellation Policy

I understand that cancellations made less than 24 hours in advance are billed at the rate of service except for emergency situations/illness.

Tricare

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 will renew the referral for Playworks through my child's primary physician every 365 days.

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.

Parent Signature: _____

Date: _____