Playworks

Speech, Occupational, and Physical Therapies

Consent For Services

I, _____, give permission to Playworks 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 or in the clinic. While my child is receiving services, I will either remain on the premises, or be reachable by phone at the following number:. : _____.

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.

Social Media: Please initial one next to your preference below (only pick one)

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

I **DO NOT** give permission for Playworks staff to use my child's image in marketing materials such as social media posts and website updates _____.

Fees:

* 50 minutes of speech/language therapy - $160.00
* Speech/Language assessment - $320.00
* 50 minutes of reading therapy/Orton-Gillingham - $125.00
* speech/language assessment report - $160.00
* 50 minutes of occupational therapy - $165.00
* Occupational therapy assessment - $750.00
* Abbreviated occupational therapy assessment $600.00
* 50 minutes of physical therapy - $175.00
* 50 minutes of developmental intervention - $110.00

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* 50 minutes of social groups - $110.00
* 50 minutes of oral motor/swallowing assessment - $175.00
*50 minutes of oral motor/swallowing assessment report - $175.00
* Feeding assessment flat rate - $750.00

I 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.

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.

Attendance Policy:

In order to maintain a consistent scheduled time with a Playworks therapist, my child needs to attend 75% of scheduled sessions. This is measured by average attendance rates over 3 months. If my child misses more than one session a month, for three consecutive months, the therapist may not be able to hold the same time slot going forward.

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Parent Signature: _____ Date:_____