Cooper River
PEDIATRIC THERAPY

PATIENT CONSENT &
AUTHORIZATION FOR TREATMENT, PAYMENT, AND OPERATIONS:
(Please initial the following statements)

_____ I have a prescription from my child's physician to authorize initial evaluation and services.
_____ I have checked with my insurance company prior to his therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co pays, and coinsurance.
_____ I hereby give Cooper River Pediatric Therapy, LLC permission to evaluate and treat my child, and I understand there will be written, oral and electronic communication between care providers/physicians, insurance companies, and Cooper River Pediatric Therapy, LLC staff. I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.
_____ I give Cooper River Pediatric Therapy, LLC permission to submit bills directly to the insurance carrier.
_____ I have read and agree to follow Cooper River Pediatric Therapy, LLC's financial policies.
_____ I have been provided a hard copy of my HIPAA RIGHTS.
_____ I give Cooper River Pediatric Therapy, LLC permission to leave voicemails and text messages to the phone numbers I have provided. These messages may contain billing and/or health information. I understand that these text messages and voicemails are not secure forms of communication. **If "no," please indicate here: _____.**
_____ I give Cooper River Pediatric Therapy, LLC permission to occasionally take photos/videos of my child for the company website, Facebook page, and/or training purposes. I consent to have my child's photo taken. **If "no," please indicate here: _____.**

Patient Name Date

_____

Signature of Parent/Guardian Print Name

_____

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