Child's Nature, LLC
120 Eastgate Dr.
Washington, IL 61571
(309) 423-3111
(309) 416-0381 fax

Child's Name: _____

Date of Birth: _____

New Client Authorization and Consent

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):
I acknowledge that I have viewed, read, and understand the HIPPA Policy and have been informed of my rights as a patient's parent/guardian

Signature: _____ **Date**: _____

AUTHORIZATION AND CONSENT FOR TREATMENT, PAYMENT, AND OPERATIONS:
Please initial the following statements:

_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, and co-insurance.
_____ I hereby give Child's Nature, LLC permission to evaluate and treat my child, and understand there will be written, oral, and electronic communication between care givers/physicians, insurance companies, and Child's Nature, 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 the use of the information gathered.

_____ I give Child's Nature, LLC permission to submit bills directly to the insurance carrier
_____ I have read and agree to follow Child's Nature, LLC office and financial policies as outlined in the Parent Handbook.

_____ _____
Signature of Parent/guardian of Patient **Date**