Grow Pediatric Therapies

1301 Pyott Road, Suite 109
Lake in the Hills, IL 60156
P: 847-829-0922 | **F**: 847-232-6526 | **W**: www.growtherapies.org | **E**: info@growtherapies.org

POLICIES-PROCEDURES-AUTHORIZATIONS

We would like to thank you for choosing Grow Pediatric Therapies for your Family! We are committed to providing you with quality services. It is important to our professional relationship to have a clear understanding of our policies, procedures and required authorizations. Please read each section and provide your initials in each box to reflect your understanding and permissions for that section. At the bottom, your signature is required to express your full understanding of and consent to all policies, procedures, and authorizations as stated herein.

Family Involvement Policy

- I understand that, as parent/guardian, I am a part of my child's therapy team. As a part of that team, collaborative decisions between myself and my child's therapist(s) will be made regarding my child's plan of care. It is important to take many factors into consideration, and different approaches may need to be trialed to determine how to maximize progress for my individual child. I understand that at least a portion of my child's treatment sessions includes family education and consultation to review the session and any recommended home exercise program(s). I agree to remain on premise during my child's sessions should I need to be available to assist in the therapies.

Parent/Guardian Initials_____

Privacy Practices (HIPAA): Consent for Release and Use of Confidential Information

- I voluntarily give my consent to care and treatment as recommended by the therapist/s as is necessary in his/her clinical judgment. I hereby give my consent to Grow Pediatric Therapies to use or disclose, for the purpose of carrying out treatment, payment, or health care operations (TPO), all information contained in the patient records. This may include sharing/exchanging information with physicians who are caring for my child. I authorize Grow Pediatric Therapies to use my information in any way that is outside of the allowable reasons under the HIPAA regulations if deemed appropriate by the therapist, for which an accounting of disclosures will be kept.

Parent/Guardian Initials_____

Authorization for Payment and Insurance Information

- I understand that payments and/or current insurance information is required at time of service. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to Grow Pediatric Therapies. This practice does not accept responsibility for collecting unpaid or denied insurance claims or for negotiating a settlement on disputed claims. I understand that I am responsible for charges not covered by my insurance.

Parent/Guardian Initials_____

Authorization for Use of Photographs/Recordings

- I understand that my child may be photographed or audio/video recorded while participating in therapies and other related activities at Grow. These photographs and recordings may be used for the purposes of family education, progress monitoring, as well as for the purpose of promoting the services offered at Grow, either in print (i.e. magazines, pamphlets etc) or on the internet (website, social media etc). I understand that my permissions granted on this form remain in effect

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until I notify the clinic in writing of my wish to change permissions. CHECK PREFERRED BOX:

_____I GIVE my consent for photographs and recordings to be taken and used as described above.

_____I do NOT GIVE my consent for photographs and recordings to be taken and used as described above.

Parent/Guardian Initials_____

Authorization for Communication Exchanges

- I understand that communications for scheduling, treatment planning, verifying benefits, and other related topics are a necessary part of on-going therapies. I understand that such communications may be in the form of verbal exchange, phone call, voicemail message, email message, text message, or other messenger systems and I authorize use of such communication exchanges.

Parent/Guardian Initials_____

Financial Policy

- I understand that any co-pays, co-insurances, unmet deductibles, or private-pay amounts are due at the time that the services are rendered.
- I understand that if my insurance is accepted by Grow Pediatric Therapies it is ultimately patient responsibility to determine insurance coverage for the services being rendered. As a courtesy, Grow Pediatric Therapies will gather information regarding insurance coverage and will submit claims to select insurance companies; however, I understand this is **not a guarantee of coverage**. I understand that I may contact my insurance carrier directly to confirm eligibility and benefits for scheduled services. I understand that balances that have gone unpaid by my insurance carrier will be transferred to my account and will become my financial responsibility. I understand that I need to bring my insurance card and photo ID to each visit.
- I understand that it is my responsibility to obtain and provide Grow Pediatric Therapies with a prescription from my child's doctor for the scheduled evaluations and therapy, prior to starting services.
- I understand that my individual/private insurance benefits may change annually and that Grow Pediatric Therapies does not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care.
- I understand that in the event balances owed to Grow Pediatric Therapies reach or exceed $300.00, I may be asked to discontinue services until a payment can be made. Scheduled times will not be reserved in this case.
- I understand that, under certain circumstances, I may be eligible for a payment plan if deemed appropriate by Grow Pediatric Therapies. If so, I understand that any payment plan must be paid in full within a 3-6 month time period.
- In the event of non-payment of a bill, I understand that this practice shall be entitled to the right of recovery for all collection expenses, including court costs and reasonable attorney fees incurred for the purpose of obtaining payment of the amount due. If my account is transferred to a collection agency, my child may be dismissed as a patient.

Parent/Guardian Initials_____

Cancellation Policy

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- I understand that, in the event that I need to cancel a scheduled appointment, I should contact my provider directly.
- I understand that my therapist may need to cancel an appointment on occasion and that while make-up sessions are not required, they may be arranged on a case-by-case basis.
- A cancelled appointment is considered a "late cancellation" when a minimum of four hours advance notice is not given to the scheduled provider. In the event of a late cancellation, I understand that I will be charged 25% of the anticipated reimbursement for the scheduled visit which I agree to pay upon invoice receipt.
- A missed appointment in which no attempt was made to cancel is considered a "no-show". In the event of a no-show, I understand that I will be charged 50% of the anticipated reimbursement for the scheduled visit which I agree to pay upon invoice receipt.
- I understand that if I accrue three or more late cancellations and/or no-shows, I may be dismissed from services.

Parent/Guardian Initials_____

Medical Release and Liability Policy

- I understand that participation in activities at Grow Pediatric Therapies is by Parent/Guardians choice. I acknowledge that there are certain risks associated with these activities, including, by way of example, physical injury due to activity-related accidents. In addition, I acknowledge that there may be other risks inherent in these activities of which I may not be presently aware.
- **Release of Liability:** I expressly warrant that this child, named below as a participant, as well as any siblings attending the therapies, is capable of withstanding both the physical and mental demands of these activities and the environment in which they are performed. I also expressly assume all risks to the child, siblings or me, whether such risks are known or unknown to me at this time. I further release Grow Pediatric Therapies and its employees, contractors and volunteers from any claim that my child may have or that I may have against them as a result of injury or illness incurred during the course of participation in these activities. This release of liability is also intended to cover all claims that members of the child's or my family or estate, heirs, representatives or assigns may have against Grow Pediatric Therapies, and its employees, contractors and volunteers. I further agree to indemnify and hold harmless Grow Pediatric Therapies, and its employees, contractors and volunteers from any and all claims arising from our participation in its activities and programs, or as a result of injury, illness, or death of my child during such activities.
- I do hereby give permission for agents/staff/contractors of Grow Pediatric Therapies to seek and secure any needed medical attention or treatment for any participants, if in the agent's opinion such need arises. In doing so; I give permission for medical personnel to administer any needed medical treatment they deem appropriate. As the Parent/Guardian, I agree to pay any/all fees and costs arising from actions to obtain medical treatment.

Emergency Contacts

Name#1_____ Relation _____Phone_____
Name#2_____ Relation _____Phone_____
Please describe any special medical needs or concerns such as asthma, allergies, dietary needs, recurring medical conditions and other Information that therapist staff should know about the participant:

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Parent/Guardian Initials_____

Acknowledgements and Consent

I represent that I am the parent/guardian of the child listed, who is under 18 years of age (or is older but for whom I am an authorized representative). I have read and agree to Grow Pediatric Therapies policies, authorizations, and Waivers. I give permission for the child named to participate in all activities at Grow Pediatric Therapies, either onsite or offsite. I hereby consent to all sections above for which I have initialed, on behalf of my child, and agree that this consent shall be binding upon me and my estate. I understand that all consents and authorizations herein are valid until revoked by me in writing. Written revocations must be directed to Grow Pediatric Therapies. I also understand that I will not be able to revoke consents in cases where the practice has already relied on these forms for such purposes. I understand that the practice has reserved a right to change any practices that are described, and that I will be notified of any changes in a reasonably timely manner.

Receipt of Notice of Financial Policy

- o I acknowledge receipt of Grow Pediatric Therapies' Financial Policy.

Receipt of Notice of Privacy Practices (HIPAA POLICY)

- I acknowledge receipt of Grow Pediatric Therapies' HIPAA Policy regarding Protected Health Information (PHI) which can be obtained on the website or in-person at the clinic.

Patient Name: (Please Print Clearly) _____Patient Birth Date:_____

Parent/Guardian Name: (Please Print Clearly)_____

Parent/Guardian Signature:_____ Date of Signature:_____