KST
Kid Sense Therapy

Client Information / Consent to Evaluate and Treat / Insurance Agreement

Patient Name: _____ DOB: _____

Address: _____

Parents: _____

Phone #: _____

Insurance Name: _____ Policy #: _____

Secondary Insurance: _____

Physician: _____

Physician Phone #: _____ Fax #: _____

Interested in (circle): **OT** **PT** **Dev. Ther.**

Scheduling preference: _____

Email: _____

Sign / Initial (below):

I, _____, give permission for my child, _____ to receive an Occupational Therapy/Physical Therapy evaluation and treatment as deemed necessary from **Kid Sense Therapy, PLLC**. I understand that this information will be used to support a developmentally appropriate goal plan for my child and will not be shared with other agencies without my prior consent. I understand that all information gathered during evaluation and treatment will be shared with me.

_____The insurance information on record for my child is current and accurate. I consent for **Kid Sense Therapy, PLLC** to bill the private insurance and/or Medicaid on record for all services. I authorize the release of medical information necessary to process the insurance claim.

_____I understand it is the insurance policy holder's responsibility to be familiar with their insurance benefits and assume responsibility for payment of services not paid by insurance.

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Release Protected Health Information

Patient Name: _____ DOB: _____

I authorize **Kid Sense Therapy, PLLC** to share specified Protected Health Information (PHI) including but not limited to: evaluation reports, treatment plans, progress notes and therapy documentation, as well as verbal communication pertaining to my child.

FROM:
Kid Sense Therapy, PLLC
616 Dr. Calvin Jones Hwy, Suite 212
Wake Forest, NC 27587
(P) 919-673-4246
(F) 877-828-3925

TO:

Name: _____ Agency: _____

Name: _____ Agency: _____

Name: _____ Agency: _____

My privacy rights have been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. Authorization is good for length of time that client is under care of **Kid Sense Therapy, PLLC**. I understand that I may revoke this authorization at any time, verbally or in writing.

_____
Signature of Parent/Guardian Date

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Patient Notification of Privacy Policies (HIPAA Authorization)

I hereby authorize use or disclosure of Protected Health Information (PHI) about my child as described below:

1.) Confidential information is stored in a secure location away from public access. All computers and PDA's are only accessed by password.

2.) **Kid Sense Therapy, PLLC** is authorized to disclose health information to insurance companies or referring physicians for the purpose of requesting doctor's orders, authorization of services, or to obtain reimbursement for services. Information may be sent via mail or fax with procedures in place to limit the likelihood of unauthorized access.

3.) **Kid Sense Therapy, PLLC** and its employees are authorized to use or disclose pertinent health information that is required for therapy purposes.

4.) **Kid Sense Therapy, PLLC** may disclose protected health information considered pertinent to care to specified professionals (e.g. social workers, teachers, physicians, therapists, etc.) with a signed release form from parent or guardian.

5.) I, the parent/guardian, understand that all employees of **Kid Sense Therapy, PLLC** are given a copy of Privacy Policy Procedures, sign a confidentiality agreement, and will only access information required to complete their job responsibilities.

6.) I, the parent/guardian, may revoke this authorization by notifying **Kid Sense Therapy, PLLC** in writing of my desire to revoke it. However, I understand that any action already completed prior to the request to revoke this authorization cannot be reversed, and my revocation will not affect those actions.

7.) This authorization expires when the client is discharged from therapy, although the company will always use professional discretion when sharing any PHI.

_____ _____

Parent/Guardian signature Date

_____ _____

Parent/Guardian printed name Patient's name (printed)

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Waiver and Release of Liability

In agreeing to receive care provided by Speech Therapy Solutions and Kid Sense Therapy, PLLC located at 616 Dr Calvin Jones Hwy, Ste 212 Wake Forest, NC 27587, I agree as follows:

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Speech Therapy Solutions and Kid Sense Therapy PLLC and the therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Speech Therapy Solutions and Kid Sense Therapy PLLC, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Speech Therapy Solutions and Kid Sense Therapy PLLC, or by any other person. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Speech Therapy Solutions and Kid Sense Therapy PLLC and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Speech Therapy Solutions and Kid Sense Therapy PLLC.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE **SPEECH THERAPY SOLUTIONS** AND **KIDS SENSE THERAPY, PLLC** FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

_____ _____

Patient's name Patient's DOB

_____

Parent/Guardian printed name

_____

Parent/Guardian signature

_____

Date