Welcome to Pediatrics Plus!

We are so honored that you have chosen Pediatrics Plus to provide therapy services for your child. We are committed to serving you and your child to the best of our ability. Below are some commonly asked questions that will help you understand the therapy process. We understand that this process is new to most families; therefore, we are always available to answer your questions and assist you in any way. Please take this letter home and keep it for future reference.

My child was recommended to have a therapy evaluation. Now what?

- Contact Pediatrics Plus and tell us that you need to make a referral for your child to receive therapy. We will take in all pertinent information for your child and then contact your pediatrician's office for a prescription for the evaluation. We will verify your funding source for eligibility and coverage of therapy evaluations. If your funding is through insurance, a representative from the Pediatrics Plus team will contact you to explain your benefits and provide additional funding options for you if needed. When we have received the prescription and approved funding, the referral manager or a therapist will then contact you to schedule the evaluation.
- If you need to cancel your child's evaluation appointment for any reason, please contact Pediatrics Plus as soon as possible. Following two cancellations of evaluations, it will be up to the discretion of the therapy director as to whether a subsequent evaluation will be scheduled by Pediatrics Plus.

Why do you contact my insurance company to verify benefits?

- Pediatrics Plus is committed to providing the best care for all families, and this includes being sure that your family is not put under financial stress due to receiving therapy for your child. We want all families to be aware of any out-of-pocket costs that may occur before services are rendered. We will do everything possible to provide additional funding options for you if your insurance company does not cover the therapy that your child needs. Due to this, it may take a little longer to get your child's therapy started.

My child qualifies for therapy. Now what?

- After your therapist performs the evaluation, they have one week to turn the report into our administration office. If your child qualifies for therapy, we will send a copy of the report to you in the mail, as well as to your pediatrician for a prescription for treatment. If your child has insurance, we will then go through the steps to ensure proper funding for therapy services. This may mean several phone calls between you and our office; please remember that the prompt return of calls will ensure that your child's services are started as soon as possible. After we have approved funding and received a new prescription for treatment, a therapist will contact you to set up the therapy sessions. Please note that the therapist who performed your child's evaluation may or may not be the same therapist that will provide treatment.

My child qualified for therapy, and it has not started yet. What do I do?

- Sometimes it can take up to 3-4 weeks after your child has been evaluated for therapy sessions to begin. We could be waiting on a prescription for therapy from your child's pediatrician or we could be waiting on a decision from you regarding your funding options. The best way to keep this process moving is to stay in contact with our office. We are always happy to address any concerns or answer any questions that you may have.

How often will my child receive therapy?

- The amount of therapy that your child will receive is based on your child's specific needs that are determined by the evaluating therapist. The therapist will include recommendations for therapy in your child's report; this report will also include specific goals that your child will be working towards during therapy sessions.

My child did not qualify for therapy but was recommended to be re-evaluated. What do I do?

- If a child does not qualify for therapy services at the time of the initial evaluation, the therapist may recommend the child return in 3-9 months to be re-evaluated. If your child receives these recommendations and your pediatrician is in agreement, we will contact you at the recommended re-evaluation date to see if you feel that the re-evaluation is necessary. In order for us to perform the re-evaluation, we will have to request a new prescription from your pediatrician's office. However, if at any time you feel that your child needs to be re-evaluated, please contact our office and we will be happy to assist you.

Empowering Children to *Conquer* Their World!

Pediatrics Plus Financial Policy

Thank you for choosing Pediatrics Plus. We are committed to providing the best services possible to your family. Once you have provided your personal financial information, our administrative and billing team will work very hard to make sure your paperwork is filed accurately and promptly.

In order to provide you with the highest quality service while keeping costs manageable, we simply maintain your credit, debit, or check card number on file to satisfy all co-pays, deductibles and balances not covered by your insurance if your child receives treatment services. An authorization form will be provided to you if it is determined that your child qualifies for treatment.

We accept all major credit cards (with the exclusion of American Express). For evaluation fees, our office accepts cash, checks, debit, and credit cards.

INSURANCE & INSURANCE COLLECTION

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, reduce and even recoup payments. To that end, our billing staff has undergone extensive training to maximize your insurance reimbursement, while reducing the time by which they pay. By signing this form, you indicate that you have read and understand the terms which provide information on your current plan and other types of plans should your insurance change. Thank you.

Non-contracted or Indemnity Plans:
We may bill your insurance as a courtesy. Our office, as a convenience and a service to you, will absorb all costs incurred for billing. In the event that your insurance does not reimburse us within 60 days, or sends notice the charges are not payable, we can simply transfer the balance of your account to your credit, debit or check card on file. Otherwise, payment in full will be expected within 30 days of the notice from the insurance company.

Plans for which we are Participating Providers:

HMO Plans: All co-pays must be satisfied each and every visit. There can be no exceptions due to contracting and uniform compliance rules.

PPO Plans: We have agreed to accept the discounted rate from your insurance plan, however all co-insurance, co-pays, deductibles and non-covered or non-payable portions are your responsibility. We will estimate balances to the best of our ability for pre-payment and after your insurance has cleared, any unpaid balance may be applied to your credit, debit or check card on file.

Self-Insured Plans: If we are not contracted with the insurance administrator of your employer or your HMO, we may bill your plan as a courtesy. In the event the plan does not reimburse us within 60 days, we may simply transfer the balance of your account to your credit, debit or check card on file. Otherwise, payment in full will be expected within 30 days of the notice.
Secondary Insurances: Having more than one insurer DOES NOT necessarily mean that your services are covered at 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your insurances have cleared. We can bill the balance to your credit, debit or check card on file. Otherwise, payment in full will be expected within 30 days of the notice.

Usual & Customary Rates: Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

ADDITIONAL INFORMATION:

I understand that even though I may have some type of insurance coverage, I am fully responsible for payment of services rendered. If I have a deductible, I will be responsible for paying at the time of service if my deductible has not been met.

If the balance on my account is greater than 90 days, the account may be turned over for collection unless arrangements are made with the billing department in advance. If my account is turned over for collection, I understand that services will be terminated.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

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Patient Liability Statement

We **will not** initiate therapeutic services until signed authorization is provided.

I understand that I am personally responsible for charges incurred for services rendered by the office of Pediatrics Plus if any of the following apply:

1. My health plan does not cover 100% of the services rendered for any reason.
2. I do not provide Pediatrics Plus with the correct insurance information.
3. I have chosen not to use my medical coverage at the time services are rendered.
4. I have a medical plan with a carrier that would be considered by this office to be "out of network".
5. My benefit parameters limit or exclude coverage for therapy services.
6. My coverage changes during the course of therapy.
7. I exceed my benefit limitations.

I understand that claims not paid after 60 days by in-network providers automatically become the responsibility of the guarantor/subscriber.

I understand that if I must appeal my insurance company's decision regarding coverage, I will pay for services (past and present) until the appeal process is complete.

I understand that outstanding balances that are not paid within 60 days will be charged to the credit card I have on file with Pediatrics Plus.

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Parent Policies and Procedures

Sign-In Policy

In order for us to be efficient and have quality treatment sessions with your child, ***we require that you sign them in*** with the receptionist at the front desk and leave a phone number where you can be reached if needed. You are required to stay in the lobby with your child until the therapist arrives. This will avoid the possibility of children waiting alone without the therapist knowing they are here. Also, when your child's treatment session is over, ***we ask that you sign them out***; this will avoid the possibility of having your child released without proper supervision.

Waiting Room Policy

In order to keep a clean and sanitary environment, we ask that no food or drinks be brought into the waiting area (with the exception of bottles). We understand that it is necessary for many of you to bring siblings with you to therapy, and we have no problem with this. However, we ask that you keep them with you in the waiting area during your child's therapy session. This lessens the possibility of a child having an accident or getting lost in the therapy area. Siblings are welcome to watch TV or play in the waiting room while you wait on your child to get out of treatment. We do ask that, if watching TV, the shows be appropriate for all ages. We also ask that any siblings/children in the waiting area be under constant supervision from parents/guardians.

Facility Policy

Due to safety concerns and to provide the most optimal environment for therapy, only children receiving therapy will be allowed past the door from the waiting room into therapy areas. Children receiving therapy will be accompanied by an adult therapist at all times. We want our parents to always be involved in their child's therapy but do encourage you to speak with individual therapists concerning the child's performance and level of distraction with observation.

Evaluation Cancellation Policy

In the event that you need to cancel your child's evaluation appointment for any reason, please contact Pediatrics Plus as soon as possible. Following two cancellations of evaluations, it will be up to the discretion of the therapy director as to whether a subsequent evaluation will be scheduled by Pediatrics Plus.

No-Show Policy/ Cancellation Policy

We understand that there will be times when circumstance arise that will require your child to miss therapy. We ask that you please notify us as soon as you know if/when your child will have to miss. You can contact your therapist directly if you have her number; or you can call the front desk and the message will be relayed to the therapist.

The "No-Show" Policy is as follows:

- If your child misses 3 consecutive therapy sessions without any prior notification, we will discharge him/her from the therapist's caseload. If your child misses 4 random therapy sessions without prior notification throughout the course of one month, we will discharge

him/her from the therapist's caseload. We also reserve the right to discontinue therapy because of too many cancellations. This will be at the therapists' discretion.

- Before your child is discharged, we will follow the following steps:
    1. A warning letter will be sent after 2 sessions have been missed with no prior notification or after 4 sessions have been missed with notification.
    2. If sessions are still being missed, the therapist will contact you to discuss the importance of treatment for your child and to make you aware of upcoming session times.
    3. A letter of discontinuation will be sent if child is still missing all or most of his/her therapy sessions, and the therapist will discharge the child from her caseload.

We hope you understand that we strive to provide a quality convenient service to all of our patients and their parents. Thank you for your assistance in helping us do this.

Late Drop-off Policy

If you are running late, the therapist will wait 15 minutes after the scheduled therapy session start time for your child. After that, it will be at the therapist's discretion whether or not to treat your child that day. Individuals who are consistently late for appointments may be discontinued from a therapist's caseload following warning from administration.

Late Pick-up Policy

If you drop your child off for treatment, you must be back to pick them up on time. If you are not back to pick your child up when his/her treatment session is over, you will be charged $1 per minute for every minute past the end of the child's therapy session. Our therapists have patients scheduled all day long, and it is important for them to treat each patient at their scheduled time. If you plan on leaving the clinic while your child is in treatment, please check with the therapist to confirm the correct pick up time. If there is an emergency, please notify us, and we will be able to keep your child until you can get to the clinic to pick him/her up.

Sick Policy

If your child has had viral symptoms (fever, diarrhea, vomiting, etc…) within 24 hours prior to his/her scheduled treatment time, please call and cancel the appointment. This helps to maintain a healthy environment in the clinic for the staff and other patients.

Restroom Policy

We have a restroom in our waiting area for you or your children if needed.

Inclement Weather Policy

In the case of severe inclement weather, Pediatrics Plus may open later than usual or close. You can watch the local television stations and/or call the front desk and listen to the automated message. It will notify you of closings or late openings. If the local public-school district is closed, Pediatrics Plus will have an automatic 9:00 a.m. opening unless otherwise noted on the automated message and television stations.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU/YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose: This notice of Privacy Practices describes how we may use and disclose you/your child's Protected Health Information (PHI) to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. "Protected Health Information" is information that may identify you/your child and that relates to your past, present, or future health, and may include you/your child's name, address, phone numbers and other identifying information.

We are required to give you this notice and to maintain the privacy of you/your child's PHI because of the privacy regulations of the federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Pediatrics Plus will obey the rules of this notice as long as it is in effect, and if we make any changes, the rules of the new notice will also apply to all the PHI we keep. If we change this notice, we will post the new notice in our office. Because this law and the laws of this state are very complicated, we have simplified some parts. If you have any questions or want to know more about anything in this notice, please ask our Privacy Officer to contact you.

We understand that medical information about your health is personal and confidential, and we are committed to protecting the confidentiality of your medical information. We create a record of the care and services you receive at Pediatrics Plus. We need this record to provide services to you and comply with certain legal requirements. This notice will tell you about the ways we may use and disclose your health information. We also describe your rights and certain obligations we have to use and disclose your health information.

If you believe your Privacy Rights have been violated, you may complain to us or to the U.S. Secretary of Health and Human Services.

If you have questions or need more information, contact our Privacy Officer at 501.328.3274.

Who Will Follow This Notice: This notice describes the practices of Pediatrics Plus' healthcare professionals, employees, volunteers and others who work at Pediatrics Plus.

Acknowledgement: You will be asked to sign an Acknowledgement of receipt of this notice. The delivery of your healthcare services will in no way be conditioned upon the signing of this acknowledgement.

Your Privacy Rights: You have the following rights related to your Protected Health Information, and you may:

- Obtain a current paper copy of this notice. If we change this notice, we will post it in the waiting area of our clinic.
- Request to inspect or obtain a copy of your records. Your request to obtain a copy of your medical records must be in writing. You may be charged a fee for the cost of copying, mailing, or

other supplies. We are allowed to deny this request under certain circumstances. For example, under federal and state law, you may be denied access to inspect or copy Pediatrics Plus notes.

- Obtain a record of certain disclosures of your Protected Health Information.

We will obtain your written permission for uses and disclosures of your Protected Health Information that are not covered by the notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must also be in writing.

Our Responsibilities: We are required to protect the privacy of your PHI, abide by the terms of the notice, and make the notice available to you if we are unable to agree to a requested restriction or an alternative means of communicating.

Examples of Uses and Disclosures:
We will use your PHI for treatment. We use your medical information to provide you with treatment of services. These might include evaluation and testing, therapy progress notes, and treatment planning.

We may share or disclose your PHI to others who provide treatment to you, such as your personal physician. We may also consult with other professionals or consultants.

We will use your PHI for payment. Under some circumstances, we may provide information about your diagnosis, treatments, progress, and duration of treatment plan to an insurance company or other third party payer.

We will use your PHI for regular healthcare operations. The providers may use your PHI to check on the care you received, how your child responded to it, and for other business purposes related to the operating of the clinic.

Business Associates: We may share some of you PHI with outside people or companies who provide services for us, such as record keeping.

As required by law: we must disclose your PHI when required by federal, state, or local law, including law enforcement for public health, abuse and/or neglect, and other legal proceedings.

Required uses and disclosures: We must make disclosure when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.

To avoid harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety and/or the health or safety of the public or another person.

As noted, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer at 501.328.3274.

Effective Date of This Notice: October 1, 2003

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Notice of Teaching Institution and Affiliations

Pediatrics Plus is a teaching institution. We are currently affiliated with and have established student placement agreements with several in and out of state university therapy programs. Throughout the year, we will have students coming to our facility who are interested in pediatrics. Several therapists in various disciplines have agreed to be clinical instructors of these students. If your child's therapist will be an instructor, your therapist will notify you at that time. Each session will be supervised by your child's regular therapist. The student may also need access to your child's file to learn more about him/her and plan the most appropriate treatment.

Being a clinical site is beneficial to everyone involved. The children always love having student participants in the sessions. The staff is also able to keep current on the latest techniques and knowledge of various disciplines. The students also provide new ideas for your child's treatment program, which makes therapy more enjoyable for your child.

If you have any questions regarding this arrangement, please contact Pediatrics Plus. Thank you for your time and cooperation.

Pediatrics Plus Patient Information

Patient's Name	Today's Date:
Social Security Number:	Sex: (Please circle one) Male Female
Date of Birth:	Race:
Referred by/ How did you hear about us?	
#1 Parent/Legal Guardian:	
Relationship to Patient:	Social Security Number:
Address:	City, State, Zip Code:
Primary Phone Number:	Alternative Phone Number:
Place of Employment:	Work Phone:
Check here if Custodial Parent: □	Email Address:
#2 Parent/Legal Guardian: □same household	
Relationship to Patient:	Social Security Number:
Address:	City, State, Zip Code:
Primary Phone Number:	Alternative Phone Number:
Place of Employment:	Work Phone:
Check here if Custodial Parent: □	Email Address:
Is your child currently in or have previously been in foster care placement? (Please Circle One) YES NO	
Emergency Contact – Not Living in the Same Household	
Name:	Relationship:
Primary Phone Number:	Alternate Phone Number:
Address:	City, State, Zip Code:
□ By checking this box, caregiver choose to not designate anyone else as an emergency contact.	
Primary Care Physician Name:	
Address:	City, State, Zip Code:
Phone Number:	

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Primary Funding Information (if applicable)	
Company Name:	Phone Number:
Address:	City, State, Zip Code:
Member ID or Policy #:	Group #:
Name of Policy Holder:	Date of Birth of Policy Holder:
Secondary Funding Information (if applicable)	
Company Name:	Phone Number:
Address:	City, State, Zip Code:
Member ID or Policy #:	Group #:
Name of Policy Holder:	Date of Birth of Policy Holder:
Patient's Birth History (Please be as thorough as possible)	
Child was born at _____ weeks.	Birth Weight: _____lbs. _____ ozs.
Was delivery via c-section? YES NO	If yes, please list reason:

Please describe any medical problems during pregnancy and/or birth for the mom: _____

_____

Please describe any medical problems during pregnancy and/or birth for the child: _____

_____

Child's health at birth: (NICU, Oxygen, etc.): _____

_____

General Medical History (since birth)

Surgeries/Hospitalizations/Serious Accidents (please list with dates) : _____

_____

Childhood or other illnesses: _____

_____

Medications: _____

_____

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Allergies (Food, Medications, Other):	
Allergic to:	Reaction:
Allergic to:	Reaction:
Allergic to:	Reaction:
Allergic to:	Reaction:

Does your child <u>currently receive</u> any of the follow therapies? (Please list <u>Start Date</u> of each)			
OT:	PT:	ST:	ABA:
If yes, where does your child receive services:			

Has your child:	
Had a history of ear infections? YES NO	Tubes placed in ears? L R N/A Date: _____

Had any feeding, nutritional, or dietary problems? YES NO
If yes, please explain:_____

Is your child on a special diet? YES NO
If yes, please explain:_____

Been diagnosed with any of the following: *<u>Autism</u>*: YES NO *<u>ADHD</u>*: YES NO
Other – Please Explain: _____

Has your child been diagnosed with a behavioral health condition (e.g. depression, anxiety, bipolar, etc.)? YES NO
If yes, please list the diagnosis: _____
What was the date of diagnosis? _____

Has your child ever had treatment for a behavioral health condition? YES NO
If yes, please list the date(s) and provider(s) of treatment: _____
Please list the type of treatment provided: _____
Please describe the response to treatment: _____

Does your child require any special equipment (wheelchairs, standers, IV poles, etc): YES NO
If yes, please explain:_____

Are your child's immunizations up to date? YES NO
If yes, please provide a copy of the child's most current immunization record.
If no, does your child have an immunization waiver? YES NO
If your child has an immunization waiver, please provide Pediatrics Plus with a copy of the waiver letter listing the immunizations the child has waived.

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Medical/Nursing Services:
Please circle any medically necessary services that your child could potentially receive during a therapy session and/or our preschool program:

Tube Feeding	Medications	Catheterizations
Oxygen	IV Line (s)	Blood Sugar Monitoring

Other: _____
For any circled item, please explain (frequency, amount, etc): _____
_____

General Development and Social History:
Please list the age at which your child has met the following developmental milestones, if applicable:

Babble (use of consonants): _____ Single Word Use: _____	Pull to Stand: _____ Walk: _____
Sit without support: _____	Finger Feed: _____
Crawl: _____	Potty Trained: _____

Can your child follow simple, age-appropriate instructions? YES NO

Does your child attend: SCHOOL CHILDCARE BOTH
If so, please list name of the school and/or childcare: _____
If you child is in school, what type of classroom is he/she in? _____

Does your child nap on a regular basis? YES NO

Does your child have night time sleeping issues? YES NO
If yes, please explain: _____

Family Medical History
Please list others living in the same household:

Name:	Relationship to Child:
Name:	Relationship to Child:
Name:	Relationship to Child:
Name:	Relationship to Child:
Name:	Relationship to Child:
Name:	Relationship to Child:
Name:	Relationship to Child:

Does anyone in the child's household smoke cigarettes? YES NO

What are your primary concerns about your child? _____
_____
_____

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Has anyone in the child's family ever had any of the following? (Please mark which family member in the corresponding box)

	Mother	**Father**	**Sibling**	**Grand-mother** (indicate M for maternal and P for paternal)	**Grand-father** (indicate M for maternal and P for paternal)	**Extended Family** (aunt, uncle, cousin, etc.)
Attention/ADHD Problems						
Speech Problems						
Motor/Vocal Tics						
Depression						
Anxiety						
Bipolar						
Schizophrenia						
Learning Disability						
Sickle Cell Disease						
Seizure Disorder						
Alcoholism						
Drug Abuse						
High Blood Pressure						
Lung Problems/Asthma						
Heart Problems						
Behavior Problems (please specify):						
Other (please specify):						

I authorize the following persons to pick up my child from Pediatrics Plus:

Name	Phone Number	Relationship to Child

I, the undersigned, certify that I have provided accurate information and answered all questions on this form truthfully to the best of my knowledge. I authorize Pediatrics Plus to release any information including the diagnosis and the records of any treatment and examination rendered to my child to custodial parents and/or legal guardians, third party payers, health practitioners, my attorney(s), and/or any other person or institution to whom I have given a separate Release for Medical Information, as necessary. I authorize and request my insurance company to pay directly to Pediatrics Plus benefits otherwise payable to me.

I understand that it is my responsibility to keep Pediatrics Plus informed of any change in the above information.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Child's Name: _____ DOB: _____

Address: _____

I authorize PEDIATRICS PLUS

☒ to disclose my health information to _____ Primary Care Physician
(Name of Physician, clinic, hospital, self, etc)

☒ **and I authorize the Covered Entity** _____ Primary Care Physician
(Name of Physician, clinic, hospital, self, etc)

to disclose my health information to PEDIATRICS PLUS.

Purpose of use, disclosure, or request: ☒ Continuity of care & treatment; □ At the request of the patient;

□ Payment; ☒ Medical history; ⍰ Other issues (specify) _____

Information to be used and/or disclosed:
☒ Clinical (Example: History & testing; therapist reports; EI treatment plan; clinic treatment plans)

□ Other (specify) _____

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol or drug abuse; psychiatric or mental illness; domestic violence; child abuse; incarceration; legal difficulties; and/ or sexually transmitted diseases, including HIV or AIDS virus.

This authorization will expire upon termination unless you specify a different expiration date, event or condition:
Please specify: _____

I understand that I have a right to revoke this authorization at any time except to the extent that the release of information has already occurred in reliance on my prior authorization.

I understand that to revoke an authorization, a written document stating the intent of the patient is to be either delivered in person or by certified mail to The Center of Early Learning. The revocation document is to contain the signature of the patient or patient's legal representative.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.

I understand that any disclosure carries with it the potential for re-disclosure by the recipient of this information and such re-disclosure may not be protected by federal confidentiality laws.

_____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

CONSENT TO RECEIVE OUTPATIENT THERAPY SERVICES

I give consent for my child, _____, to receive therapy services through Pediatrics Plus Therapy Services, Inc. (d/b/a "Pediatrics Plus"). Outpatient therapy services include any or a combination of the following: evaluation, individual therapy, and group therapy. I consent to allow my child to participate in program activities directly associated with his/her evaluation and treatment, and as appropriate, to involve my child's family members. I authorize Pediatrics Plus to review my child's medical record for teaching purposes. I understand that all the personal information that I provide about my child and our family will remain confidential and any published data will keep the identity of my child and family confidential. I authorize Pediatrics Plus, or any of its successors, assigns, or related entities, to file for insurance benefits to pay for the care my child receives. I understand that Pediatrics Plus will have to send my child's medical information to my insurance company. I also understand that I must pay my child's share of treatment costs, specifically those costs my insurance does not pay or if I do not have insurance. I declare that I am this child's legal guardian and have full authority to make all educational and medical decisions on behalf of my child.

DISCONTINUATION OF TREATMENT POLICY

NO SHOW POLICY: All new and follow up appointments must be cancelled at least 24 hours prior to the appointment time. Cancellation or reschedule requests on the day of the appointment are considered NO SHOW appointments.

Please be aware that Pediatrics Plus Therapy Services, Inc. may discontinue your child's treatment for any of the following reasons:

- Achievement of treatment goals.
- Failure to appear for four or more appointments within a one-month period, without at least a 24-hour notification.
- Being consistently late for appointments or consistently cancelling appointments.
- Not participating in treatment for a period of 90 consecutive days.

I hereby certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Parent or Guardian **Date**

_____ _____

Printed Name of Parent or Guardian **Relationship to Patient**

_____ _____

Signature of Witness **Date**

Permissions Signature Page 1 of 3

Child's Name: _____

Child's Date of Birth: _____

Parent/Guardian Printed Name: _____

Pediatrics Plus Financial Policy

I have read, understand, and accept the Pediatrics Plus Financial Policy. I assign my insurance benefits to Pediatrics Plus. I understand this form is valid for the duration of my child's treatment unless I cancel the authorization through written notice to Pediatrics Plus.

_____

Parent/Guardian Signature Date

Patient Financial Liability Statement

I have read and understand the Patient Financial Liability Statement summarizing policy and procedures set forth by Pediatrics Plus. By signing below, I hereby agree to the terms and conditions and authorize Pediatrics Plus to provide services to my child.

_____

Parent/Guardian Signature Date

Parent Policy and Procedure Packet

I, the undersigned, have read the parent policy and procedure packet and agree to adhere to the included information to ensure the best experience for the children of Pediatrics Plus.

_____

Parent/Guardian Signature Date

Permissions Signature Page 2 of 3

Child's Name: _____

Child's Date of Birth: _____

Parent/Guardian Printed Name: _____

Notice of Privacy Practices

I, the undersigned, have read and agree to the above privacy practices for Pediatrics Plus.

_____

Parent/Guardian Signature Date

Consent for Students

Pediatrics Plus is a teaching institution. We have affiliated with various national universities as a clinical site for the nursing, education, psychology, and therapy departments. These universities will send students to our facilities throughout the year to learn from some of our team members. The student may participate in your child's care. A Pediatrics Plus team member supervises each student. The students may need to access your child's medical record to learn more about him/her and plan the most appropriate treatment. All students are educated on HIPAA/privacy issues and have signed a privacy agreement confirming to abide by all Pediatrics Plus policies and procedures.

☐ CONSENT: We/I hereby certify that We/I are/am the parent(s) or guardian(s) of the above-named child and do hereby give our/my consent without reservation to the foregoing on behalf of my Child.

☐ NON---CONSENT: We/I hereby certify that We/I are/am the parent(s) or guardian(s) of the above-named child and do **not** hereby give our/my consent without reservation to the foregoing on behalf of my Child.

_____

Parent/Guardian Signature Date

Permissions Signature Page 3 of 3

Child's Name: _____

Child's Date of Birth: _____

Parent/Guardian Printed Name: _____

Media Consent and Release Form

I am the parent/guardian of _____ (print full name of child) ("My Child"). I hereby grant Pediatrics Plus and its media sub-contractors, agents, and assigns the absolute right and permission to use photographic portraits, pictures, digital images, or videotapes of My Child, or in which My Child may be included in whole or part, or reproductions thereof, in color or otherwise, for any lawful purpose whatsoever, including but not limited to use in any Pediatrics Plus publication, advertisement, social media post, or on the Pediatrics Plus website, without payment or any other consideration.

I hereby waive any right that I may have to inspect and/or approve the finished product or the copy that may be used in connection therewith, wherein My Child's likeness appears, or the use to which it may be applied.

I hereby release, discharge, and agree to indemnify and hold harmless the Pediatrics Plus, and its owners, employees, insurers, media sub-contractors, agents, and assigns from all claims, demands, and causes of action that I or My Child have or may have by reason of this authorization or use of My Child's photographic portraits, pictures, digital images, or videotapes, including any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said images or videotapes, or in processing tending towards the completion of the finished product, including publication on the internet, in brochures, or any other advertisements or promotional materials.

I represent that I am at least eighteen (18) years of age and am fully competent to sign this Release.

☐ CONSENT: We/I hereby certify that We/I are/am the parent(s) or guardian(s) of the above-named child and do hereby give our/my consent without reservation to the foregoing on behalf of My Child.

☐ NON---CONSENT: We/I hereby certify that We/I are/am the parent(s) or guardian(s) of the above-named child and do **not** hereby give our/my consent without reservation to the foregoing on behalf of My Child.

_____

Parent/Guardian Signature Date