



FOR KIDS

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CONSENT FORM

Authorization for Treatment

Patient Name _____ Medical Record _____

I, _____
(parent or legal guardian name)

Give my consent for Dynamic Therapy For Kids personnel to provide the services listed below.

_____ Consultation _____ Evaluation _____ Treatment

I authorize treatment to be performed at the following treatment sites:

Office ____ Daycare ____ School ____ Home ____

Authorization for Supervision during Therapy Sessions

The following persons may be present in the absence of the parent/guardian during therapy sessions:

I consent for Dynamic Therapy For Kids to use the patient's Protected Health Information (PHI) for the purpose of providing treatment, payment of services, and for Dynamic Therapy For Kids general healthcare operations purposes. PHI means for any information, including demographic information, created or received by Dynamic Therapy For Kids that relates to past, present or future health conditions; information that relates to the provision of health care; information that relates to past, present or future payment for the provision of health care services; and information that can be used to identify the patient.

I have received the Notice of Privacy Practices and understand the conditions under which information will be used and disclosed.

Authorization for Billing and Payment of Services

I authorize Dynamic Therapy For Kids to contact Medicaid and /or private insurance company to confirm benefits and release information necessary to process claims. I authorize payment directly to Dynamic Therapy For Kids for services rendered. I understand that I am responsible for any co-pay/co-insurance and /or deductible amounts associated with the patient's benefits. I understand that it is my responsibility to know my benefits and that verification of benefits by Dynamic Therapy For Kids is not a guarantee of payment.

Signature _____ Date _____