



Pediatric Therapy Partners

PHYSICAL THERAPY • OCCUPATIONAL THERAPY • SPEECH-LANGUAGE THERAPY

3003 32nd Avenue South • Suite 9 • Fargo, ND 58103 • Phone 701.232.2340 • Fax 701.232.2330

www.PediatricTherapyPartners.com

PATIENT ACKNOWLEDGMENT FORM

Our **Notice of Privacy Practices** (“Notice”) provides information about: 1.) the privacy rights of our patients; and 2.) how we may use and disclose protected health information (“PHI”) about our patients.

Federal regulation requires that we give our patients or their authorized representatives (“You”) the opportunity to review our Notice before signing this acknowledgment. A two-page summary of our Notice is displayed in our office. A copy of our Notice will be made available to you either upon request or you may visit our website at www.PediatricTherapyPartners.com.

If you have any questions about your rights or our privacy practices please send an electronic message (e-mail) to info@PediatricTherapyPartners.com or a letter to:

Privacy Officer

Pediatric Therapy Partners

3003 32 Avenue South, Suite 9

Fargo, North Dakota 58103

We will respond to you within five (5) business days.

AUTHORIZATION TO BILL INSURANCE STATEMENT

Consents & Assignments

I understand that if appropriate, Pediatric Therapy Partners will bill my Health Plan for services to be rendered. However I also understand that pursuant of North Dakota law, Pediatric Therapy Partners is authorized to bill me directly under the following conditions.

Insurance Assignments

I authorize and assign payment directly to Pediatric Therapy Partners involved in my child’s treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance.

Insurance Changes

I understand that as the individual responsible for payment that I am also responsible in providing insurance updates/changes to Pediatric Therapy Partners in a timely manner. **I understand if these changes are not reported in a timely manner I shall be responsible for charges incurred that are not covered by my Health Plan, which could be substantial.** Please inform us immediately of any changes in coverage so we can avoid this scenario.

RELEASE AUTHORIZATION

INITIAL HERE _____ if you also agree to grant consent to Pediatric Therapy Partners and its employees, to take and use visual/audio images of you or your child(ren). “Visual/audio images” includes any type of recording whatsoever including but not limited to photographs, digital images, drawings, renderings, voices, sound or video recordings, audio clips or accompanying written descriptions. Such potential uses include educational, promotional, advertising, and trade, through any medium or format.

I waive any right to inspect or approve the finished images or any printed or electronic matter that may be used with them, or to be compensated for them. I hereby freely and voluntarily consent to the use and publication of the images by Pediatric Therapy Partners from this date forward until I revoke this consent in writing.

By signing this form, you acknowledge that we have provided you with immediate access to our Notice of Privacy Practice, that you agree with the authorization to bill insurance statement, and that you reviewed the release authorization use of visual/audio images.

SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN

Signature of Patient or Authorized Representative

Date

Print Name of Authorized Representative

Print Name of Patient