COMPREHENSIVE THERAPY CHILDREN'S CENTER

SPECIALIZING IN PEDIATRIC OCCUPATIONAL, PHYSICAL AND SPEECH THERAPY

PATIENT AGREEMENT

Child's Name _____ **Birthdate** _____

This agreement is entered into by and between Nimble Kids, LLC, dba Comprehensive Therapy Children's Center and _____ , legal representative for the patient named above.

CONSENT FOR SERVICES

I hereby consent to any and all examinations and treatments prescribed for the patient by his/her physician and provided by **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center.** These services may include Physical, Occupational, and/or Speech Therapies.

ASSIGNMENT OF BENEFITS/FINANCIAL AUTHORIZATION FOR INSURANCE

I agree to allow **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center** to bill the third party listed below on an assignment of benefits basis for Therapy Services provided to my child. I further authorize payment directly to **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center** of any benefits for Therapy Services. I also agree that I am financially responsible and will pay all charges not paid by any third party payer including, but not limited to, any deductibles, coinsurance, or any nonpayment in whole or in part by the third party payer. I further agree to notify **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center** within 48 hours if payer source is changed. I understand that if I fail to provide this notification, I shall be responsible for any charges not paid by the third party payer.

_____ Legal Representative Initials

Insurance Company _____
Policy Holder Name _____
Policy / Contract # _____
Group # _____ Phone # _____
Case Manager _____

FINANCIAL AUTHORIZATION FOR MEDICAID

I understand that application for payment may be made on the patient's behalf and that information needed may be given in order for **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center** to receive such payment under Medicaid. I hereby request that payment of authorized government health benefits otherwise payable to the patient, be made directly to **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center** for and on the patient's behalf. I further agree to notify **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center** within 48 hours if the payer source changes or the patient is enrolled in a Medicaid HMO. I understand that if I fail to provide this notification, I shall be responsible for any charges not paid by the third party payer.

_____ Legal Representative Initials

Legal Name of Beneficiary _____
Medicaid # _____

SELF PAY

I agree that I am financially responsible and will pay all charges for Therapy services received by the patient.

_____ Legal Representative Initials

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PATIENT AGREEMENT (PAGE 2)

FINANCIAL POLICY

I acknowledge that I have received, read, and understand the Financial Policy of **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center.**

_____ Legal Representative Initials

PHOTOGRAPH AND VIDEO RELEASE

I authorize **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center** to take and retain still and video images of my child to serve as a visual record of my child's condition and progress. I understand that without additional, written consent on my part these records will not be published, released, or used in any manner other than to assist the staff in assessing and monitoring my child.

_____ Legal Representative Initials

INFORMATION REQUEST

I authorize **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center** to release information from the patient's medical records, including, but not limited to, his/her complete medical history and records relating to tests, diagnoses, and treatments, to Medicaid, other third payers, other providers of health care or social services, or to the patient's service providers through Babies Can't Wait or the school system. I also grant permission for medical facilities, physicians, and Babies Can't Wait and the school system to disclose all or part of any medical record to **Nimble Kids, LLC, dba Comprehensive Therapy Children's Center**.

_____ Legal Representative Initials

CERTIFICATION

I certify that I understand the foregoing. I also certify that I am the patient's legal representative duly authorized to execute the above and accept the terms of this agreement.

I have read, or the information provided has been read to me, and I fully understand this form and have asked any questions that I might have. I understand that by signing this form, I indicate that I have the understanding and the capacity to make and communicate health care decisions on behalf of the patient.

Legal Representative Signature	Date	Print Full Name

Relationship to Patient

Witness	Date	Print Full Name