sensory in motion
therapy services

CONSENT FORMS

Patient's Name: _____Birth date:_____

HIPPA/PRIVACY NOTICE
I have received and reviewed a copy of this Notice of Privacy Practices Summary. I understand that if I would like a copy of the Privacy Notice it is my right to receive one upon request.

_____ _____ _____
Parent/Guardian Signature Date Witness

POLICIES & PROCEDURES
I have read the Policies & Procedures and agree to follow the terms of all.

_____ _____
Responsible Party's Signature Date

REQUEST FOR INFORMATION
I hereby give my consent to any physician, hospital, school, or clinic to release the information requested concerning the diagnosis and/or treatment of the client named below, to Sensory in Motion Therapy Services, LLC. This information will be utilized in determining the most appropriate diagnostic and treatment procedures for the below named client and will be treated as confidential.

_____ _____ _____
Child's Name Parent/Guardian Signature Date

RELEASE OF INFORMATION
I hereby give my consent for Sensory in Motion Therapy Service, LLC to release my child's information to the following persons/entities (List name & date on same line):

_____ _____

_____ _____

_____ _____

_____ _____ _____
Child's Name Parent/Guardian Signature Date

VIDEOGRAPHY/PHOTOGRAPHY/WEBSITE
I hereby give my consent for any videography or photography for purposes of recording the patient's functional status for medical records or for commercial use.

_____Yes _____ No

_____ _____
Parent/Guardian Signature Date

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AUTHORIZED COMMUNICATION

If we are unable to speak with you directly by phone, is it okay for us to leave detailed information on your voicemail, e-mail, or text message?

Voicemail: □ Yes □ No Authorized Phone Number: _____

E-mail: □ Yes □ No Authorized E-mail Address: _____

Text Message: □ Yes □ No Authorized Phone Number: _____

_____ _____ _____

Child's Name Parent/Guardian Signature Date

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, I authorize Sensory in Motion Therapy Services, LLC, its officers, employees, and/or representative to:

- Secure and retain medical treatment and transportation if needed & release any records upon request to authorized individual/agency involved in treatment.

Patient's Name: _____ Birth date:_____

Physician's Name: _____ Phone: _____

Please describe any medical conditions that may require special precautions or treatment and any medications the patient is now taking:_____

List any allergies to medications the patient might have._____

Person(s) to Contact Phone Number(s) --Include cell phones:

_____ _____

_____ _____ _____

Child's Name Parent/Guardian Signature Date

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Financial Agreement

Payment For Services
Payment is due at the time service is rendered. Sensory in Motion therapy Services, LLC does not wait or collect payment directly from your insurance company. We accept cash, checks, and major credit cards. Returned checks will be subject to a $25.00 returned check fee.

Billable Services
You will be charged for an initial evaluation and for each subsequent treatment session. Consultations may be subject to a consultation fee. Consultation fees will not be reimbursable with your insurance company. Consultations subject to fees include but are not limited to IEP meetings, meetings within the school, or 30 minute training sessions with parent/caregiver/consultant. While there is no ordinary charge for a brief telephone consultation, more lengthy or complex situations may result in charges. Some reports may also result in charges.

Insurance Coverage
Our services are not guaranteed to be covered by your insurance. We will provide you with necessary documentation for you to submit claims to your insurance company. You are responsible for obtaining the insurance reimbursement and contesting insurance denials. We are happy to provide any requested paperwork to support your claim.

- Sensory in Motion Therapy Services, LLC will assist you in receiving reimbursement from your insurance company by providing you with the necessary documentation to submit claims. You are responsible for following up with your insurance company to make sure that you are being reimbursed correctly.
- If your insurance company or contracting agent denies a claim or makes an incorrect payment on your child's account, we will attempt to assist you. You will need to bring the Notification Letters or Explanation of Benefits letters to Sensory in Motion Therapy Services, LLC. We will submit Appeal letters as appropriate if asked, and we will immediately correct any billing errors made on our part to assist you in the process of making sure your insurance company is paying their portion of the bill. However, you are ultimately responsible for payment.
- Please also note that you are using "Out-of-Network" benefits with your insurance company for your sessions with Sensory in Motion Therapy Services, LLC. Your insurance company will assign a "Reasonable & Customary" amount to the charges we bill. This "Reasonable & Customary" amount is how much your insurance company will pay for each Treatment Code billed. Therefore, there will likely be a difference between the "Reasonable & Customary" amount the insurance company will reimburse you and our actual billed amount. Please recognize that most insurance companies will expect you to meet a deductible amount before reimbursement.

I acknowledge that I have read and understand my responsibility to pay for services. By signing this agreement, I agree to the terms of this document.

_____	_____	_____
Child's Printed Name	Parent/Guardian Signature	Date

Sensory in Motion Therapy Service, LLC
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