

JOINT CONSENT FORM

Consent to Release/Obtain Information/Payment/Treat & Acknowledgment That You Have Received Our HIPAA Privacy Notice

I have been informed of the use and release of information collected through services received in regards to:

Patient's Full Name: _____ I request that copies of information in regards to my child be released to/from:

1. _____ <i>Child's Doctor</i>	2. _____ <i>Payer/Insurance</i>
3. _____ <i>Other Doctors</i>	4. _____ <i>School-if Appropriate/Daycare</i>
5. _____ <i>Babynet- if applicable</i>	6. _____ <i>Other</i>

Please read the following and then initial below.

- _____ I request that payment of authorized Medicaid and third party payer's benefit be made to Therapy Consortium Inc., and when applicable East Coast Therapies, on my behalf for services furnished to me.
- _____ I authorize Therapy Consortium Inc. and East Coast Therapies to release any medical information about me that may be needed to determine these benefits payable for related services.
- _____ I understand that I will not be billed for any Medicaid services furnished to me which were billed to Medicaid during the time I had Medicaid coverage for those services.
- _____ I understand that Therapy Consortium Inc. and East Coast Therapies are required by law to give me a copy of the privacy notice. I understand how my health information may be used and shared.
- _____ I understand that Therapy Consortium Inc. and East Coast Therapies are required by law to keep my health information safe.

This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history & any treatment notes
- Test Results
- Insurance information

By signing this page you consent to have your child treated by Therapy Consortium Inc. and East Coast Therapies for Speech, Occupational and Physical Therapy Services and that you have been given a copy of our privacy notice.

Patient's Name: _____

Patient/Guardian Signature: _____

Witness: _____

Date: _____

Date: _____