# AUTHORIZATION AND CONSENT FOR TREATMENT, PAYMENT, AND OPERATIONS:

Please initial the following statements:

_____ I have a prescription from my child's physician to authorize initial evaluation.

_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays and co-insurance.

_____I hereby give KidsCare Therapy Center, Inc permission to evaluate and treat my child, and understand there will be written, oral, physical, and electronic communication between care providers/physicians, insurance companies, and KidsCare Therapy Center, Inc staff. I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my child's records. I understand that all practices of confidentiality will be followed in use of the information gathered.

_____ I give KidsCare Therapy Center, Inc permission to submit bills directly to the insurance carrier.

My signature below signifies that I have read and understand the authorization and consent for treatment, payment and operations.

_____ _____/_____/_____

Signature of Parent/Guardian of Child Date



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