3488 Jeffco Boulevard, Ste 102
Arnold, Missouri 63010
Phone: 636-464- KIDZ (5439)

CONSENT TO TREAT / RELEASE / FINANCIAL AUTHORIZATION

Patient Name: ____ **DOB:** _____________________________________

1. CONSENT FOR TREATMENT:
   I hereby authorize Therapeutic Playtime to carry out all procedures as ordered by my physician on the Plan of Treatment.

2. RELEASE OF INFORMATION:
   I authorize Therapeutic Playtime, Inc. to release to or receive from hospitals, or other agencies involved in my care, records related to my care. These records will be utilized to facilitate my treatment and to coordinate my care among service providers. I also authorize my records to be reviewed by authorized representatives of my third party payor, physician or other health care providers related to my care. I understand I, or my authorized representative, may revoke this consent at any time upon written notice. I further authorize access to my records by officials coordinating on-site surveys with accrediting, licensing or other regulatory organizations. I understand my records will be kept confidential and only shared with those persons listed above as needed. I further understand the agency will keep my record in a secure place and only allow authorized individuals to access it.

3. ASSIGNMENT OF BENEFITS:
   I hereby authorize Therapeutic Playtime benefits due me covering such expenses under stated insurance coverage. Therapeutic Playtime will reduce the amount owed by me by the amount paid on my behalf by my insurer.

4. FINANCIAL AGREEMENT
   I agree to accept financial responsibility for all services provided to me by Therapeutic Playtime. I also agree to promptly pay all bills in accordance with the applicable rates and terms, which can be modified by agreement between the provider and my health care insurance company. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. I understand that if my account is delinquent, it will incur interest at the legal rate.

5. PHONE CALLS:
   I authorize Therapeutic Playtime and its collection agencies to contact me, or a representative I appoint, about my account, including using contact information or cell phone numbers that I have provided or will provide, or that is available to Therapeutic Playtime from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages. I agree with such contact will not be "unsolicited" for purposes of local, state, or federal law.

THERAPEUTIC PLAYTIME MAY ACCEPT ASSIGNMENT FOR INSURANCE BENEFITS COVERING THE ABOVE SERVICES. HOWEVER, I UNDERSTAND THAT I REMAIN RESPONSIBLE FOR PAYMENT OF SUCH CHARGES AND FOR ANY AMOUNTS STILL OWED AFTER CONSIDERATION OF BENEFITS BY ANY AND ALL THIRD-PARTY PAYORS. Verification of benefit eligibility does not guarantee payments. Responsible party is obligated for payment of services in full.

6. **FINANCIAL AUTHORIZATION:**
I have been informed of the following charges, which will be incurred for services rendered.

IF WE BECOME AWARE OF CHANGES IN YOUR COVERAGE ANYTIME DURING YOUR COURSE OF TREATMENT, YOU WILL BE NOTIFIED IMMEDIATELY OF YOUR FINANCIAL RESPONSIBILITY, AND IF YOU BECOME AWARE OF ANY CHANGES NOTED IN COVERAGE, YOU WILL CONTACT THERAPEUTIC PLAYTIME, INC. AS NECESSARY.
Responsible party will be obligated to pay a minimum of $85.00 per session for treatment, $150.00 for evaluation if coverage changes or lapses and agency is not notified in advance.

____ ______________________
Signature of Patient or Responsible Party **Date**

____ ________________________________
Address of Responsible Party

____ ________________________________
Signature of Witness **Date**