A DIFFERENT KIND OF PERFECT

ADKOP

PEDIATRIC THERAPY, LLC

CONSENT FORM

Patient Name:_____ Date of Birth:_____

I am the patient's parent/guardian and am authorized to make decisions on their behalf:

_____ _____

Parent/Guardian Name Relationship to Patient

_____ _____

Address Phone Number

Is your child placed with you by the foster care system?	Yes	No
If yes, please answer the following questions:		
1.)Are you the patient's Medical Consenter?	Yes	No
2.)Does the patient have a Back-Up Medical Consenter?	Yes	No
3.)Do you have a Form 2085-B designating you as the patient's Medical Consenter?	Yes	No

Consent for Evaluation and Treatment:
I authorize A Different Kind of Perfect Pediatric Therapy, L.L.C to provide home health evaluation and treatment for the following services for my child as prescribed by his/her physician:
Circle all that apply:

Speech Therapy Physical Therapy Occupational Therapy

I understand that services provided by A Different Kind of Perfect Pediatric Therapy's licensed speech, occupational, and/or physical therapists whom evaluate(s) and treat(s) my child will discuss my child's recommended plan of care with me, will give me the opportunity to ask questions regarding the recommended therapy services and will ask my input regarding the development of my child's plan of care. I understand that A Different Kind of Perfect Pediatric Therapy staff members will answer my questions regarding evaluations, recommended plan of care and therapy services. I understand that my child's plan of care is subject to change and that I will be consulted when a change is made. _____ (Initial)

Consent to Release Information:
I authorize A Different Kind of Perfect Pediatric Therapy to use and disclose my child's health information for the purpose of treatment and payment. This includes, but is not limited to release of information to physicians, insurance companies, surveyors, employees, contractors, and other healthcare professionals. I have reviewed a copy of the agency's privacy policy detailing the privacy practices and my child's rights. _____ (Initial)

Consent to Bill Insurance:
I authorize A Different Kind of Perfect Pediatric Therapy to bill and collect payment from my child's insurance company. A representative from A Different Kind of Perfect has explained my child's insurance benefits to me, and we have discussed the amount, if any, that I will pay for services rendered. I understand that I am responsible for all charges that are not covered by my child's insurance company, including but not limited to co-pays, deductibles, and coinsurance. I agree to notify A Different Kind of Perfect immediately of any changes regarding insurance companies or if I lose eligibility. I understand that I will be responsible for any charges incurred if I do not inform the agency about all insurance changes. _____ (Initial)

Insurance and Payment Information:
Insurance provider and policy numbers are on file. Below is the breakdown of what insurance is responsible for and what you are responsible for evaluation and therapy charges: _____ (Initial)

Insurance Pays: _____% Patient Pays: _____%

Other Arrangement: _____

Patient Rights:
I have received a copy of my child's patient rights, and I have been given the opportunity to ask questions. _____ (Initial)

Complaint Procedures and Reportable Conduct:
I have received information on the agency's procedures for complaints and reportable conduct. I understand that if I wish to file a complaint, I may contact the administrator of A Different Kind of Perfect Pediatric Therapy, L.L.C. At **(817) 823-9077,** the Texas Department of Aging and Disability Services at 1-800-458-9858, or the Accreditation Commission for Health Care at 1-855-937-2242. _____ (Initial)

Supervision of Services:
I understand that services provided by therapy assistants will be supervised in accordance with licensing regulations. _____ (Initial)

Alleged Abuse, Neglect or Exploitation Policy:
I have received a copy of the agency's Investigations of Complaints and Reports of Alleged Abuse, Neglect or Exploitation Policy. _____(Initial)

Disclosure of Drug Testing Policy:
I have received a copy of the agency's Disclosure of Drug Testing Policy. _____(Initial)

Advanced Directives:
I have received information regarding Advanced Directives. _____(Initial)

The Patient has an Advanced Directive, which is on file with _____
Name of Hospital/Facility

The Patient does not have an Advanced Directive. _____(Initial)

Emergency Preparedness and Safety:
I have received information on emergency preparedness and safety. I agree to accept responsibility for myself and my family in the event of an emergency. _____ (Initial)

Patient Class Rating: *SELECT ONLY ONE*

- **Level 1:** Low risk (visits may be postponed 72 hours or more) _____
- **Level 2:** Average risk (needs care within 24-72 hours) _____
- **Level 3:** High risk (requires ongoing care) _____

Home Safety Assessment:
A Different Kind of Perfect Pediatric Therapy's staff members have discussed any safety concerns that were found during admission with me. These concerns include:
_____
_____
_____. _____(Initial)

I acknowledge that I have received the Agency's above mentioned policies and all information has been adequately explained to me. I understand that this agreement may be terminated by either party at any time. I also understand that I can request copies of the paperwork in the consent package that I have signed by contacting the agency office at (817) 823-9077.

_____ _____
Parent/Guardian Date

_____ _____
A Different Kind of Perfect Representative Date