occupational - physical - speech/language therapy
for pediatrics

Communicable Disease Policy

It shall be the policy of Infinity Children's Services to abide by the following:

All patients, or parents and guardians of patients, shall cancel and reschedule appointments when the patient may have one or more symptoms of a contagious disease. This will aid in the protection of the health of the staff, other patients, and family members.

Symptoms:

- fever > 100 degrees Fahrenheit
- vomiting or nausea
- open or draining lesion
- lice
- chicken pox
- measles
- productive cough
- impetigo
- conjunctivitis
- pink eye
- strep throat
- diarrhea
- any other contagious disease not listed

I understand and agree to abide by the above stated policy.

_____ _____

Signature Date

occupational - physical - speech/language therapy for pediatrics

Attendance Policy

In order to provide your child with timely appointments and outstanding therapy services, it shall be the policy of Infinity Children's Services to abide by the following:

- We ask for 24-hour notice for all cancellations. Failure to provide notification will be considered a no-show. Three consecutive no-shows or excessive cancellations will result in your child being placed on probation and subject to reduction of the scheduled appointment slots.
- We ask that you keep to an 80 percent or greater attendance record. Again, excessive cancellations will result in the above mentioned probation and the reduction of your hcild's scheduled appointment slots.

We realize that unforeseen emergencies happen, and sometimes 24-hour notice is not possible. Please notify us as soon as possible, so we can reschedule your appointment.

We appreciate the confidence you have shown us in allowing Infinity Children's Services to provide therapy for your child. As we continue to grow, we are committed to providing the best possible service to your and your child.

I understand and agree to abide by the above stated Attendance Policy.

_____ _____

Signature Date

occupational - physical - speech/language therapy
for pediatrics

Emergency Policy

In the event that I am unavailable when an emergency occurs, I authorize Infinity Children's Services to have my child taken to _____.
hospital

I understand and agree to abide by the above stated Emergency Policy.

_____ _____
Signature Date

Emergency Contact (other than myself):

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Authorization for Treatment, Assignment of Benefits, Payment Responsibility, and Release of Information

Patient Name: _____ Provider: _____

Authorization for Treatment: The undersigned hereby authorizes Infinity Children's Services and/or any of their contractors (collectively referred to as "Provider"), to render to patient physical therapy, occupational therapy, speech therapy, audiology, psychological services, and other related services (collectively referred to as "Therapy Services") that Provider and/or patient's physician determine to be necessary and advisable. The undersigned agrees to cooperate with all reasonable request of Provider in connection with Provider's rendering of Therapy Services.

Assignment of Benefits: The undersigned hereby assigns and transfers to Provider the right to all third party payments (including Medicare, Medicaid, and/or private insurance benefits) to which the undersigned may be or become entitled to for Therapy Services rendered by the Provider. The undersigned hereby authorizes Provider to apply and file for all such benefit payments on behalf of the patient and direct that such payments be made directly to the Provider. Any insurance benefit payments received by the undersigned for services rendered by the Provider shall be paid to the Provider.

Payment Responsibility: The patient shall be financially responsible for any portion of the Provider's invoice that is not paid, except for payments denied by Medicare or in the event of covered services provided to Medicaid recipients. The undersigned agrees to execute any and all documents and perform any acts that Provider may reasonably request to ensure that all third party benefits for Therapy Services are paid to Provider.

Release of Information: The undersigned hereby certifies that all information provided by the undersigned is true and accurate in all respects. The undersigned hereby authorizes Provider to disclose any information, medical and nonmedical, furnished to or obtained by Provider in connection with patient's diagnosis and/or treatment, to any physician, government agency (including the U.S. Department of Health and Human SErvices, or any of its intermediaries or carriers), insurance company or healthcare providers request such information. The undersigned agrees to allow Provider access to patient's medical records and agrees to allow Provider to make copies of such records. The undersigned consents to the discussion by Provider of the patient's medical condition with patient's family members for medical claims management purposes.

Executed the _____ day of _____ in the year _____ .

_____

Patient Signature *Reason patient unable to sign, if applicable*

_____

Patient's Authorized Representative Signature *Relationship*

_____

Agency Representative Signature

Responsible Party: _____

Employer: _____ *Your Driver's License #:* _____

Employer Address: _____ *Tele:* _____

Spouse Name: _____ *Employer:* _____

Employer Address: _____ *Tele:* _____

Nearest Relative: _____ *Tele:* _____

Who, not living with you, may we contact in case of an emergency? _____

Address: _____ *Tele:* _____

occupational - physical - speech/language therapy
for pediatrics

Patient Communication

In the event that Infinity Children's Services needs to contact you regarding appointments or treatments, please give us the authority to leave messages on an answering machine or with other persons as necessary.

Patient Name: _____

I authorize Infinity Children's Services to leave messages concerning the above named patient to the following persons:

_____

_____

_____

_____

☐ I authorize ICS to leave messages on an answering machine.

Should your patient communication preferences change, it will be the responsibility of the parent or guardian to inform Infinity Children's Services in writing.

_____ _____
Signature Date

_____ _____
Name Relationship

occupational - physical - speech/language therapy for pediatrics

Acknowledgment of Receipt

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Infinity Children's Services.

_____ _____

Signature Date

_____ _____

Name Relationship

Release Waiver for Photography

I give permission to Infinity Children's Services to use pictures of my child in publications, at events, on Facebook, our website, or on display in the clinic.

_____ _____

Signature Date

_____ _____

Name Relationship