

**Consent for purposes of Treatment, Payment and Healthcare Operations:**

I consent to the use or disclosure of my protected health information by TERRIO Therapy-Fitness, Inc. for the purposes of evaluation or providing treatment to me, obtaining payment for my health care bill or conducting health care operations of TERRIO Therapy-Fitness, Inc.. I understand that evaluation or treatment of me by TERRIO Therapy-Fitness Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. TERRIO Therapy-Fitness, Inc. is not required to agree to the restrictions that I may request. However, if TERRIO Therapy-Fitness, Inc. agrees to a restriction that I request, the restriction is binding on TERRIO Therapy-Fitness, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent that TERRIO Therapy-Fitness, Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review TERRIO Therapy-Fitness, Inc. HIPAA Notice of Privacy Practices prior to signing this document. The TERRIO Therapy-Fitness, Inc. HIPAA Notice of Privacy Practices has been provided to me. The HIPAA Notice of Privacy Policies describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the TERRIO Therapy-Fitness, Inc.. The HIPAA Notice of Privacy Practices for TERRIO Therapy-Fitness, Inc. is also provided at the front desk and on the TERRIO Therapy-Fitness, Inc. website at [www.myTERRIO.com](http://www.myTERRIO.com). This HIPAA Notice of Privacy Policies also describes my rights and TERRIO Therapy-Fitness, Inc. duties with respect to my protected health information.

TERRIO Therapy-Fitness, Inc. reserves the right to alter the TERRIO Therapy-Fitness, Inc. HIPAA privacy practices in order to reflect any changes to the federal HIPAA policies. I may obtain a privacy practices by accessing the TERRIO Therapy-Fitness, Inc. website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

**Patient/Guardian Initials:** \_\_\_\_\_

**Release of Information:**

The undersigned authorizes TERRIO Therapy-Fitness Inc. whether signing as patient or guardian, to release medical information as requested by insurance companies, employers, and other responsible parties, unless otherwise directed. If authorization to release information is denied, payment for services rendered will be due at time of services.

**Patient/Guardian Initials:** \_\_\_\_\_

**Assignment of Insurance Benefits:**

The undersigned agrees, whether signing as patient or guardian, direct payment to TERRIO Therapy-Fitness, Inc. of any insurance benefits otherwise payable to or on behalf of the undersigned for evaluation and treatment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment. I understand that any co-pay or share or cost will be charged and I am responsible for payment of any such charge that may be due. **I understand that a \$28.00 late fee will be charged to my account if I do not pay my balance off in full within 60 days of the balance being transferred from my insurance to myself.** All co-pays are due at the time of service. I also authorize TERRIO Therapy-Fitness to deposit checks received on my account when made out to me.

**Patient/Guardian Initials:** \_\_\_\_\_

**Cancellation/No Show Policy:**

All missed appointments are documented in your child's chart. Due to the number of children needing therapy and our limited availability at TERRIOKids, if your child misses three appointments in a row or four out of six appointments, he/she will be taken off the schedule. We understand there will be extenuation circumstances at times and believe this allows for some flexibility. Please call before your child's appointment to cancel if they are not going to be able to attend their session. If no effort has been made to reschedule, TERRIO Therapy-Fitness, Inc. will attempt to contact the Parent/Guardian. After the third failed attempt to schedule the patient, the therapist will contact the referring physician and advise discharge from therapy due to non-compliance by the patient. This policy helps insure the treatment necessary for fast recovery and we appreciate your cooperation with this policy.

**Patient/Guardian Initials:** \_\_\_\_\_

**Photo Use Authorization:**

I hereby authorize TERRIO Therapy-Fitness, Inc to take photographic images of me (my child, if signed by parent of minor) during any/all aspects of my / my child's treatments and utilize such images for purposes of marketing, including television, print, and internet.

**Patient/Guardian Initials:** \_\_\_\_\_

**Patient/Guardian Authorization for Treatment:**

I hereby grant my consent for therapy evaluation and treatments rendered by TERRIO Therapy-Fitness, Inc. Also, my initials indicate that I have read and acknowledge the above topics, respectively.

Patient Name (Print): \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Patient/Guardian Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Rev. April 12, 2011