Big Sky Collaborative Assessment & Care

New Patient Consent and Admission Form

Patient's Name: _____
DOB: _____

1. Authorization and Consent for Treatment:

I hereby consent to and grant permission to the employees and contractors of Big Sky Pediatric Therapy, PLLC and/or Big Sky Pediatric Therapy Collaborative Assessment and Care, LLC (collectively referred to hereafter as "Big Sky") to render to my child routine clinical care including, but not limited to: evaluations, educational services, and therapy activities/procedures, and to carry out the orders of my child's physician, including consultants, associates and assistants of his/her choice. As part of this consent, I acknowledge that Big Sky has not made any guarantee or warranty as to the results of any services or treatments provided. Further, by signing this form, I represent to Big Sky that I have the legal right or authority to consent to treatment for the above-named Patient. I understand that by signing this Consent for Treatment that I am providing Big Sky with the authority to provide treatment that is deemed necessary to the above-named Patient and that said authorization will continue as long as the Patient remains in the care of Big Sky, or until I withdraw my consent in writing.

Initials _____

2. Authorization for Use and Disclosure of Protected Health Information:

I understand that as part of Patient's treatment, Big Sky creates and maintains paper and/or electronic records describing any health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning Patient's care and treatment;
- A means of communication among the many health professionals who may contribute to Patient's care;
- A source of information for applying Patient's diagnosis and information to Patient's bill;
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing our internal processes.

I further understand that as a part of Big Sky's treatment, payment, or health care operations, it may become necessary to disclose the Patient's protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I hereby expressly authorize Big Sky to furnish and release the Patient's protected health information to my private insurance carrier, or other third party payer, as may be required for the determination of benefits payable. Respecting my privacy and anonymity, I understand that my child's records may be reviewed for statistical purposes. I grant permission for Big Sky to communicate all aspects of my child's care with the physician(s) whom I have identified.

Initials_____

3. Cancellation and No Show Policy:

Big Sky requires 24-hour notice for all appointment cancellations. If 24-hour notice is not provided, a $100 fee will be charged for each occurrence. A $100 fee will also be charged for any "no-shows" for booked appointments.
**Exceptions may be made on a case by case basis.

Initials_____

4. Credit Card on File

Big Sky requires that all Patients have a credit card on file for billing purposes. You will be notified prior to any charge of $150 or more.

Initials_____

5. Insurance Coverage:

Big Sky will submit claims to your insurance provider if requested. Submission of claims is not a guarantee of coverage or payment and all insurance payments are subject to medical necessity and eligibility at the time services are rendered. I understand that an office visit and specific therapy charges are incurred at each appointment. Knowledge of maximum number of visits, deductible amounts and out of pocket maximums are your responsibility. It is your responsibility to promptly update us on any changes made to your insurance.

Co-pays, deductibles and coinsurance are due at the time of service. In the event that you carry an account balance sixty (60) days from your initial statement, you will be assessed a late fee of 15% of the balance (minimum of $20) monthly until paid in full. If the balance is not paid upon the 120th day, your account will be sent to a third-party collection agency. If you are unable to provide Big Sky with your current insurance information prior to your child's appointment, payment will be due in full for that day's visit. **If your insurance delays payment and, as a result, your balance remains unpaid for a period of (60) days, Big Sky requires that you pay that balance immediately.**

Big Sky endeavors to file insurance claims promptly and accurately to ensure full payment by your insurance company. However, a credit card (Visa, MasterCard or AMEX) is required to be kept on file for each patient so that any outstanding balance, after insurance payment is received, can be paid immediately. You will be contacted if the charge is over $150.

Questions regarding insurance claims or payments should only be directed to management of Big Sky and not to treating therapists.

Initials_____

6. Children in waiting room:

Children are to *never* be left alone in the waiting room. If a child is left alone, you will incur a charge of $5 for every 5 minutes that the child is alone.

Initials_____

7. Certification:

I hereby certify that all information provided by me to Big Sky in this form or through the course of the above-named Patient's treatment is correct to the best of my knowledge. I agree that a copy of this form shall be valid as the original and will not expire. I represent that I have read this form (or it has been read to me) and I certify, understand and agree to all of its conditions and have been given an opportunity to ask questions about it.

_____ _____ _____

Parent/Guardian Signature Relationship to Patient Date