AUTHORIZATION FOR TREATMENT

____I authorize Thera-Peds, LLC to treat my child.
____I authorize Thera-Peds, LLC to release my child's records to the insurance company for payment of benefits.
____I authorize my child's records to be released to the referring physician or other treating physicians.
____I authorize my child's records to be released to the proper medical personnel in case of an emergency.
____I authorize Thera-Peds, LLC therapists to consult with other therapists or doctors of the patient.
____I hereby authorize reimbursement directly to Thera-Peds, LLC. I also agree that if the insurance company issues payment directly to me for these services, I will pay the amount issued by my insurance company to Thera-Peds, LLC within 15 days of receiving payment.
____I understand that all co-pays, co-insurance and deductibles are collected at the time of the session.
____I understand that Thera-Peds, LLC has promised no specific outcomes as to the services provided at this facility.

AUTHORIZATION TO RELEASE INFORMATION

I give my permission to Thera-Peds, LLC to photograph and/or video my child for evaluation and marketing purposes. This may include pictures in a brochure, newspaper and/or website. Also it could include photographing to show progress and reviews.
____I give my permission
____I do *NOT* give my permission

_________________________________ _____________________
Signature Date

_________________________________ _____________________
Relationship to Patient Patient Name

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