Pediatrics Unlimited
Comprehensive Treatment Plan Agreement

Patient Name:_____ Date of Birth: _____

PRIVACY PRACTICES

I, _____, acknowledge that I have read Pediatrics Unlimited, Inc. Notice regarding Privacy of Personal Health Information. I ☐ would ☐ would not like a copy of Pediatrics Unlimited, Inc. Notice of Privacy Practices.

FINANCIAL POLICY AGREEMENT

I understand I am responsible for contacting my insurance company or primary care physician to verify benefits and for authorization of any visits to Pediatrics Unlimited, Inc. I understand I am responsible for all costs not covered by my Insurance Company. These costs include, but are not limited to: Services provided which are not covered by my policy; balances after insurance payment; or failure to obtain authorization before my appointments. I understand that co-pays are paid at the time service is rendered unless other arrangements are made. Any outstanding payments will be due by the last business day of the month to avoid interruption of services and additional charges. If a payment is not paid by the last business day of the month, a late fee of $25 will be billed to my account, and if the entire balance is not paid within 30 days, a finance charge will accrue at a rate of 12% per year (1% per month). After 3 consecutive late fees, therapy services will be terminated and collective action will be initiated. Account balances that are paid promptly will avoid these charges.

I hereby authorize Pediatrics Unlimited to release to any insurance company or liable third parties any records or information regarding the diagnosis, condition or treatment of the patient. I am agreeing to assignment to Pediatrics Unlimited all payments from insurance companies for therapy services rendered.

I have authorized services at Pediatrics Unlimited and understand that I will be billed by the 7th of each month for outstanding balances. The bill must be paid by the last business day of the month. All checks are to be made payable to Pediatrics Unlimited. All service charges for any checks returned for Insufficient Funds is my responsibility.

I understand that according to benefits information available at the time of my evaluation, my deductible is _____ and my copay & coinsurance responsibility is _____. I understand that this information is not a guarantee of coverage but is only representative of the information available from my insurance company at the time it was researched.

I understand that all fees are non-negotiable.

INITIAL: _____

NO SHOW / NO SMOKING POLICY

I understand that I am required to call a **minimum of 3 hours prior** to scheduled appointments to cancel, otherwise it will be considered a No Show. **Two No Shows in 6 months**, 3 **weeks of cancelled appointments in a row**, or **2 consecutive late arrivals** will result in the loss of my standing therapy appointment(s). INITIAL: _____

I understand smoking is not permitted on the premises. Failure to comply will result in loss of therapy appointment(s).

INITIAL: _____

OBSERVER POLICY

I authorize students/observers to observe my child's sessions should one be present.

INITIAL: _____

AUTHORIZATION TO PHOTOGRAPH PATIENT

I, _____, ☐ authorize PEDIATRICS UNLIMITED, INC. to photograph/videotape
☐ do not authorize PEDIATRICS UNLIMITED, INC. to photograph/videotape

Patient: _____ Date of Birth: _____

For these expressed purposes:
☐ Treatment and family education ☐ Research ☐ Publicity ☐ Training/professional development ☐ All

The photograph/videotape will not be used for any other purposes than those authorized on this form. For the privacy of others, taking pictures and videos in common areas is prohibited.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____RELATIONSHIP TO PATIENT:_____
WITNESS SIGNATURE: _____ DATE: _____