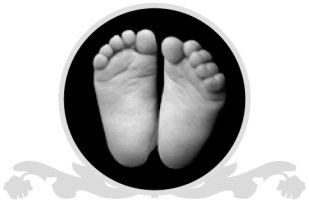


PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Dear Parents,

Thank you for choosing Pure Pediatric Therapy for your child's therapeutic needs. After scheduling your initial evaluation, please fill out the attached forms and have them ready to bring in with you at the time of your initial evaluation.

Please complete and sign the following forms **prior** to your child's initial evaluation:

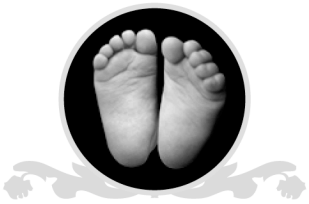
- Financial Responsibility Agreement
- Attendance/Cancellation Policy
- Authorization for release of information
- Acknowledgement of receipt of privacy practices

We encourage you to visit our website for frequently asked questions, explanations of therapy services provided, and testimonials. If you have any additional questions, please do not hesitate to call our office (949) 916-1654.

Thank you,

Pure Pediatric Therapy

Phone: **949.916.1654** • Fax: **949.916.1658** • www.purepeds.com 24422 Avenida De La Carlota, Suite 100, Laguna Hills • CA 92653



PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Patient Demographic Information

Patient Name _____ M F Date of Birth_____

Mother's Name_____ Mother's Phone Number_____

Father's Name_____ Father's Phone Number_____

E-mail _____

Home Address _____ City _____ State _____ Zip _____

Specialists involved in your child's care:

Pediatrician:_____ Phone number: _____

Neurologist:_____ Phone number: _____

Allergist:_____ Phone number: _____

Gastroenterologist: _____ Phone number: _____

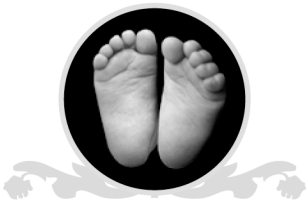
Behavioral Therapist: _____ Phone number: _____

Other: _____ Phone number: _____

_____ I authorize Pure Pediatric Therapy to use my phone number or email for appointment reminders.

Preferred email _____

Preferred phone number _____ Cell Phone Carrier: _____



PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Financial Responsibility Agreement

Pure Pediatric Therapy is committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policies. Please read through this notice and initial where applicable. If you have any additional questions, please contact your insurance company prior to arriving to your scheduled appointment. Please initial the statements and sign below indicating your understanding of the following:

_____It is your responsibility to contact your insurance company prior to receiving services. As a courtesy to our clients, Pure Pediatric Therapy, Inc. will also call your insurance company to determine your therapy benefits and coverage. **Medical insurance companies may initially state that they cover therapy. However, this is not a guarantee and they may deny services at any time**. If this occurs, Pure Pediatric Therapy, Inc., will make up to **ONE** attempt to submit your child's claims to your insurance company. After the initial attempt, we will bill you the full amount for the services provided and you will be responsible for this amount.

_____It is your responsibility to notify Pure Pediatric Therapy, Inc. of any insurance policy or benefit changes with regards to your child's services.

_____All parents are expected to contact their insurance company and verify benefits with regards to occupational, physical and speech therapy services. Please ask specifically about any "exclusions" or "limitations" to therapy benefits. **This quote of benefits from your insurance company is not a guarantee of payment.**

_____Deductibles and co-payments are due at the time therapy services are rendered.

_____If your primary or secondary insurance company makes payment to you (personally) and not to our office, due to contractual obligations, you are responsible for the entire balance between the amount paid by your insurance and the total allowable amount billed, per date of service. This includes amounts applied to your individual or family deductible, and is due upon receipt.

_____If payment is not made to your account within 60 days, your child's services will be placed on hold until the balance is paid in full.

I have read and understand the Financial Responsibility Agreement. I hereby accept all financial responsibility for the evaluation and treatment costs incurred by my child. In addition, I authorize the release of any medical or other information necessary to process claims on my behalf.

_____	_____	_____
Printed Name	Parent/Guardian Signature	Date

I herby authorize and give consent for the licensed therapists at Pure Pediatric Therapy, Inc. to provide Occupational and/or Physical therapy services, including evaluation and treatment, to my child. I understand that my child is under the care and supervision of my therapist.

_____	_____	_____
Printed Name	Parent/Guardian Signature	Date

Denied Claims Financial Responsibility Agreement

Please initial and sign the following statements indicating your understanding:

_____ My child is receiving therapy services at Pure Pediatric Therapy. I understand that my insurance benefits have been verified and although Pure Pediatric Therapy is an in-network provider, my child's therapy may be ***denied*** as an exclusion in my health insurance plan.

_____ If the claims are denied, it will be my responsibility to pay the billed amount in full for all dates of service.

_____ Once the balance is paid, I have the option of appealing the claims and obtaining reimbursement personally.

_____ I understand Pure Pediatric Therapy will provide any documentation necessary to help with the appeals process.

I have read and understand the Denied Claims Financial Responsibility Agreement for Services. I hereby accept all financial responsibility for the evaluation and treatment costs incurred by my child, should my insurance company deny the claims.

_____ _____

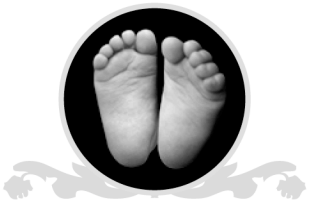
Child's Name Child's Date of Birth

_____

Responsible Party (Please Print)

_____ _____

Responsible Party Signature Date



PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Attendance/Cancellation Policy

Please review the following cancellation policy. We want to emphasize that this policy is in place to ensure quality and continuity of care for your child. Your child's pediatrician has refereed your child to us for necessary treatment and our desire is to provide the best possible care.

Cancellations must be made at least 24 hours in advance in order to avoid any charge for a therapy session. If you need to cancel an appointment after hours, you must leave a message in the General Voicemail at (949) 916-1654. THERE WILL BE NO EXCEPTIONS TO THIS POLICY, SO PLEASE READ IT CAREFULLY.

I understand and agree to the following: (*please initial and sign at the bottom*)

_____ If you "no show" or call to cancel with less than 3 hours notice, you will be billed $50.00 on your next statement. (A "no-show" is defined as a missed appointment without a call or email to inform our office) There will be NO exceptions.

_____ If your child is sick or you need to cancel your appointment on the day of your scheduled appointment, you MUST call the office within 3 hours of your scheduled time to reschedule this appointment within the SAME week (rescheduled appointments can not be during your child's next regularly scheduled appointment). If the appointment is not rescheduled, you will be billed $50.00. *We understand that your schedule is limited with other activities, school, and therapies, however there will be no exceptions made for restrictions in schedules. If the therapist's schedule is full, you will be offered to be placed on the cancellation list for the next available appointment.*

_____ After three "no shows", three times cancelling on the same day as your scheduled appointment, or habitual timely cancellations (50% of treatments scheduled) your child will lose their reoccurring treatment time will be taken off the schedule and your pediatrician will be notified.

_____ If you cancel or "no-show" a make-up appointment, you will be charged $50.00. There will be NO exceptions.

_____ Due to the importance of your child's session, if you arrive greater than 15 minutes late for your scheduled appointment, your child will NOT be seen and this will be considered an untimely cancellation, and you will be billed $50.00.

_____ In the event your therapist is sick or on vacation, you will be notified as far in advance as possible. If you would like to be seen by an alternate therapist in the meantime, please speak to the front desk to coordinate scheduling. *If your therapist cancels an appointment the same day, you will receive a "credit" on your account to be used towards a future untimely cancellation.*

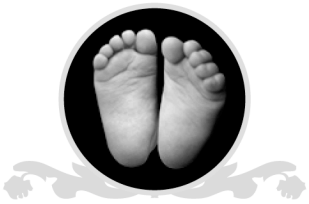
_____ Scheduled vacations or extended medical absences that require canceling three or more consecutive treatments will result in the loss of your reserved treatment time. In the event this occurs, Pure Pediatric Therapy will do our best to prioritize resuming your child's therapy upon notice of return.

Thank you for your cooperation and understanding of our cancellation policy and for helping us achieve our goal of providing the most consistent and continuous care for your child.

I have read and understand the Pure Pediatric Therapy attendance/cancellation policy.

_____ _____

Parent Signature **Date**



PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Authorization for Release of Information

My child is a client of Pure Pediatric Therapy, Inc., and I authorize the release of information and relative documentation regarding my child's participation in therapy. I understand I will be informed of the content of any conversations and release of medical information that is exchanged.

_____ _____

Child's Name Date of Birth

I authorize the release of this information to the following professionals:

Name and contact information of Medical Professionals/Educational Staff/Therapists/etc:

_____ _____

Name Contact Info

_____ _____

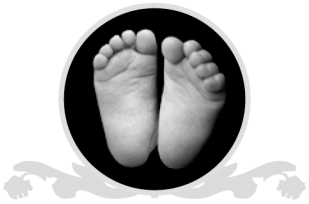
Name Contact Info

_____ _____

Name Contact Info

_____ _____

Parent/Caregiver Signature Date



PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Parent Consent

_____ As this child's parent or guardian, I give my consent and permission for my child to receive medical and wellness services by Pure Pediatric Therapy therapists and staff to include evaluations, procedures and or treatments prescribed by my physician and my child's therapist as is necessary in their judgment.

_____ Pure Pediatric Therapy has my permission to photograph and/or videotape my child to use in evaluation or treatment.

_____ Pure Pediatric Therapy has my permission to use my child's photograph/video and description of such media publically to promote the clinic. I understand that the images/videos/description may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

_____ I authorize Pure Pediatric Therapy to allow my child to use the restroom with assistance or supervision from a Pure Pediatric Therapy staff member.

_____ I understand that if I leave the clinic during my child's scheduled therapy and do not return by the end of the session, my child may not be supervised by a licensed therapist and a fee $10.00 for the first 1-15 minutes, and $1.00 for every minute thereafter, will be automatically added to my child's account.

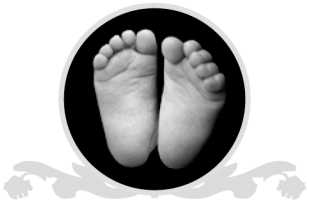
_____ I understand if I leave my child unsupervised in the lobby for any reason, Pure Pediatric Therapy is not responsible for supervision or any injury or illness that may result.

_____ I understand that Pure Pediatric Therapy is a teaching facility and I hereby give my permission for students to participate in and observe my child's therapy with a licensed therapist present.

I acknowledge that the information that has been reported in this document and to Pure Pediatric Therapy is true and correct. Pure Pediatric Therapy reserves the right to refuse therapy at any time for any reason.

_____ _____

Parent/Caregiver Signature Date



PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Acknowledgement of Privacy Practices

Patient's Full Name: _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand this information will be used to:

(a) Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly

(b) Obtain payment for services, and

(c) Conduct normal health care operations.

I understand the acknowledgement of privacy practices and understand that Pure Pediatric Therapy, Inc., has the right to change it's policies and procedures, however acknowledge that Pure Pediatric Therapy, Inc., will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. I understand that I may request a copy of Notice of Privacy Practices to provide further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, and healthcare operations, and otherwise allowed by law.

_____ _____

Signature of Parent or Guardian Date