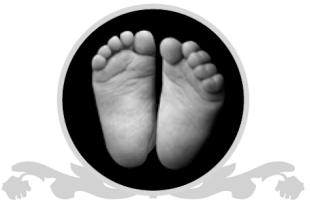


PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Patient Demographic Information

Patient Name _____ M F Date of Birth_____
Parent's Name_____ Parent's Phone Number_____
Parent's Name_____ Parent's Phone Number_____
E-mail _____
Home Address _____ City _____ State _____ Zip _____

Specialists involved in your child's care:
Pediatrician:_____ Phone number: _____
Other Specialists:_____ Phone number: _____
Other Specialists: _____ Phone number: _____
_____ I authorize Pure Pediatric Therapy to send reports, discuss the plan of care, and release information to the providers listed above. I understand that I will be informed prior to information being released.
_____ 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 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.

_____ I authorize Pure Pediatric Therapy to send appointment reminders via email or text (choose one)

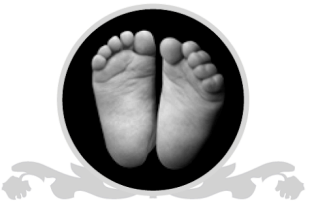
Preferred email _____ Preferred number for text reminders:_____

My Goals for Therapy are: _____

_____

_____

_____



PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Financial Responsibility Agreement

(Initial and sign below)

_____The full amount is due at the time therapy services are rendered. Our fees for visits are as follows: Initial Evaluation: $250, Treatment sessions $190/hour, Home visits $250 (additional travel fee may apply). These rates are subject to change at any time however patients will be notified of rate changes at least 30 days prior.

_____I understand that I am choosing to use a provider that is not going to bill my insurance company and that all pre-authorization requirements are my responsibility.

_____I understand that I can submit a superbill however there is no guarantee that I will be reimbursed from my insurance company for services rendered.

_____I understand that I will not be refunded the fees collected for any reason.

_____I understand that if I need to cancel my appointment without 24-hours notice, I will be obligated to pay a fee of 50% of the session fee.

By signing below, I am agreeing to the Financial Responsibility Agreement. I hereby accept all financial responsibility for the evaluation and treatment costs incurred by my child.

_____ _____ _____

Printed Name Parent/Guardian Signature Date

Consent to Treatment

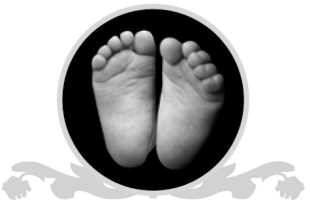
_____ As this child's parent or guardian, I give my consent and permission for my child to receive medical and wellness services by Pure Pediatric Therapy therapists and staff to include evaluations, procedures and or treatments prescribed by my physician and my child's therapist as is necessary in their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

_____ I understand that the activities in which my child and myself will engage in as part of the treatment provided by Pure Pediatric Therapy, Inc and the physical/occupational/speech therapy activities and equipment I may use as apart of that treatment have (a) inherent risks, dangers, and hazards, and that (b) my participation in such activities and or use of such equipment may result in injury including but not limited to illness, bodily injury, disease, strains, fractures, paralysis, death or other ailments that could cause serious disability and that (c)these risks and dangers may be caused by negligence of the representatives or employees of Pure Pediatric Therapy, Inc. By choosing to participate/have my child participate, I hereby assume all risks and all responsibility for losses or injuries whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Pure Pediatric Therapy, Inc. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future as well as on behalf of my personal representatives, my heirs voluntarily agree to release waive and hold harmless Pure Pediatric Therapy, Inc. from any and all claims, actions which may arise out of my participation and use of equipment in the activities at or recommended by Pure Pediatric Therapy, Inc.

By signing below, I give consent for the licensed therapists at Pure Pediatric Therapy, Inc. to provide Occupational, Physical and/or Speech 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



PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Attendance/Cancellation Policy - 2024 UPDATE

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 referred your child to us for necessary treatment and our desire is to provide the best possible care.

Email for appointment reminders: _____

Cancellations must be made at least 24 hours in advance in order to avoid any charges for a missed therapy session. If you need to cancel an appointment after hours, you must leave a message in the General Voicemail at (949) 916-1654 or email pptinfo@purepeds.com. 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 I cancel after 6pm the day before my child's scheduled appointment, I will be charged 50% of the session fee.

_____ If I "no show" a scheduled appointment, I will be responsible for 50% of the session fee.

_____ Due to the importance of my child's session, I understand that if I arrive greater than 15 minutes late for my scheduled appointment, my child will **NOT** be seen and this will be considered an untimely cancellation and I will be billed for 50% of the session fee.

_____ I understand that if I bring my child to therapy sick, I will be charged 50% of the session fee and my child will **NOT** be seen.

_____ In the event the therapist assigned to your child's case is sick or on vacation, I will be notified as far in advance as possible. If I would like to be seen by an alternate therapist in the meantime, I understand I can coordinate schedules with the front office.

I understand and agree with the above policies. I understand that untimely cancellations/no shows will result in a fee and I agree to pay the fee in full prior to my next scheduled visit. Failure to do so will result in my child being withdrawn from treatment.

_____	_____	_____
Signature of Parent/Guardian	**Date**	**Child's Name**