Caregiver's Name (Completing the Form): ____________ **Child's Name:** ______________________________

Caregiver's Phone Number: ________________________ **Child's DOB:** ______________________________

I authorize Playworks Therapy ("Playworks") to share information about my child with the following healthcare providers or individuals:

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I also grant permission for Playworks to conduct evaluations, treatment, and consultative services for the mentioned client either through teletherapy or at the clinic. During my child's sessions, I will either be present on-site or available at the phone number listed above.

I acknowledge that Playworks will maintain confidentiality by not sharing my child's information with any unauthorized individuals. All medical records and health information will be kept strictly confidential.

Consent for Rates

Assessments
The assessment rates are charged at a flat rate, covering both the in-person evaluation time and the additional time spent scoring assessments, drafting reports, and reviewing findings with parents.

Rate	Assessment
$340	Speech/Language Therapy
$750	Occupational Therapy
$750	Feeding
$370	Oral Motor/Swallowing
Physical Therapy Assessment costs change based on tests and evaluations used, specifically priced at $185, $370, and $555	

Treatment
The listed rates for services are based on a 50-minute session. For sessions shorter than 50 minutes (25 or 40 minutes), the rate will be prorated according to the actual session time.

Rate	Service
$170	Speech/Language Therapy
$125	Social Group
$170	Reading Therapy (Orton-Gillingham)
$175	Occupational Therapy
$185	Physical Therapy
$185	Feeding Therapy

Reports, treatment plans, progress notes, parent meetings, and assessments are charged at the same hourly rate. All co-treatments will be billed at the rates of both clinicians involved.?

I acknowledge that I am responsible for full payment to Playworks within ten days of service. In the absence of a provided credit card number, payment is due at the time of service. I understand that matters relating to health insurance, including policies and reimbursements, are solely between myself and my health insurance company. Playworks will directly bill me for all services rendered to the specified individual.

Consent to Policies

Cancellation Policy
I acknowledge that appointments canceled with less than a 24-hour notice will be charged the full service rate, excluding emergency situations or illness.

Attendance Policy
Maintaining a consistent time on your therapist's schedule is contingent upon adhering to our attendance policy.

The policy mandates a minimum attendance rate of 75%, equivalent to attending 3 out of 4 sessions or 6 out of 8 sessions, depending on the frequency of your monthly appointments. Please note that clinic-canceled sessions will not be considered missed appointments. In the event of missed sessions, your child's therapist will collaborate with you to arrange makeup sessions, facilitating the maintenance of the 75% attendance rate. Playworks reserves the right to charge for 75% of scheduled sessions and/or forfeit your consistent time slot if the attendance policy is not met.

Consent for Billing (Tricare ONLY)

I understand that all services covered by Tricare, Humana, will be billed directly to Humana. I am responsible for services NOT COVERED by Tricare and all co-pays. I will renew the referral for Playworks through my child's primary physician every 365 days.

Sponsor's Name: ____________________ **Sponsor's Social Security Number:** ____________________

If the social security number is not provided, Tricare will not be charged directly, and therefore I will be responsible for all charges.

Consent for Social Media

I give permission for Playworks staff to use my child's image in marketing materials such as social media posts and website updates

: ____________________

Consent for Community Outings

I give permission for Playworks staff to provide therapy services in the local community (i.e. Woodstock playground, Starbucks, CVS, etc.)

: ____________________

Signature: ____________________
Date: ____________________