CONSENT TO ADMISSION & MEDICAL TREATMENT
FINANCIAL AGREEMENT

Patient Name: _____ Date of Birth: _____

Responsible Party (Parent/Guardian): _____

Address: _____ City:_____ State: _____ Zip: _____

Telephone: (Home): _____ (Work): _____ (Other): _____

Age: _____ Gender: □ Male □ Female Diagnosis: _____

Primary Insurance Company: _____ Subscriber Name: _____

Subscriber Birthday: _____Insurance Co. Address: _____

ID#: _____ Group #: _____Ins. Phone #:_____

Secondary Insurance Company: : _____

Subscriber Name: _____

Subscriber Birthday: _____Insurance Co. Address: _____

ID#: _____ Group #: _____ Ins. Phone #:_____

Physician: _____ Clinic Name: _____

Address: _____ City:_____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Treatment Agreement: I hereby agree to treatment with Moving Mountains Therapy Center, PLLC as prescribed by my physician. I understand Moving Mountains Therapy Center contracts with Eat.Move.Grow., LLC (occupational therapy and mental health) and Stack Speech Therapy Group., LLC (speech therapy and physical therapy) to provide clinical treatment services..

Authorization for Release of Information: Moving Mountains Therapy Center, PLLC is hereby authorized to furnish and release such professional and clinical information as may be necessary for the completion of my medical claims by valid third party agents or agencies from the medical records compiled during treatment. Moving Mountains Therapy Center, PLLC, Eat.Move.Grow., LLC and Stack Speech Therapy Group.,LLC are hereby released from all legal liability that may arise from the release of said information.

Assignment and Authorization to Pay Insurance Benefits: I hereby assign and authorize payment directly to Eat.Move.Grow., LLC or Stack Speech Therapy Group.,LLC, as appropriate.

HIPPA Release: I certify that I have received a copy of the Notice of Privacy Practices effective 4-14-13, describing the privacy regulations as outlined by HIPAA and that I understand any questions regarding this privacy notice may be directed to Moving Mountains Therapy Center, PLLC (or Eat.Move.Grow., LLC or Stack Speech Therapy Group,LLC, as appropriate). I agree that these practices have been fully explained to me, and I am satisfied that I understand its consent and significance.

I (patient/legal guardian) agree to the above.

_____

Patient Signature Date Time

_____

Legal Guardian Signature Date Time

(Patient is a minor _____years of age) (is unable to consent because _____

_____

Witness Date