



Roc OTx Pediatric Occupational Therapy
Informed Consent for Treatment and Billing

**Required*

Parent(s)/Legal Guardian(s) Information:

Parent/Legal Guardian (1) Full Name*

Parent/Legal Guardian (1) Address*
(Street Number, Street Name, City, State, Zip Code)

Parent/Legal Guardian (1) Phone Number*

Parent/Legal Guardian (1) Email Address*

Parent/Legal Guardian (1) D.O.B.*

Other caregiver information, if needed:



Insurance Information:

Roc OTx Pediatric Occupational Therapy will bill your primary insurance initially. If the primary insurance does not cover the expense of treatment, your secondary insurance will be billed.

Primary Insurance information*

- Insurance Carrier:
- Policyholder's Name:
- Policy Number:
- Policyholder's Member ID #:
- Group Number/Name:
- Effective Date of Insurance:
- Relationship to patient:

Secondary Insurance information:

- Insurance Carrier:
- Policyholder's Name:
- Policy Number:
- Policyholder's Member ID #:
- Group Number/Name:
- Effective Date of Insurance:
- Relationship to patient:

CO Medicaid:

In Colorado, if a child is covered by Health First Colorado (Medicaid) and has no other insurance, Medicaid must be the sole payer for therapy services.

Does your child have Colorado Medicaid?*

- Yes
- No

If yes*, please complete the following sections

- Member Name:
- Health First Colorado ID#:
- Date of Birth:

*If you have any questions regarding insurance coverage with Medicaid or private insurance, please reach out to insurance specialist Megan Bloom at meganelizabeth@rocotx.com.



Private Pay:

If you choose to pay out of pocket, the fee is \$150 per session. By initialing below, you are permitting Roc OTx Pediatric Occupational Therapy to bill your insurance or to bill you directly for therapy services. Please review the following payment policy:

At ROC OTx, we are dedicated to delivering exceptional pediatric occupational therapy services. To ensure a smooth and transparent billing process, please review the following payment policy:

- **Payment Method:** A valid credit card must be kept on file. This allows for the timely and secure processing of payments.
- **Invoicing:** Invoices are sent out **every Monday** for services provided the previous week. Charges will be processed to the card on file unless otherwise arranged.
- **Late Payments:** If an invoice remains unpaid **30 days past the due date**, therapy sessions will be **paused** until the outstanding balance is resolved.

Initial: _____

*If you have any questions regarding billing or need to make special arrangements, please don't hesitate to contact our private pay biller, McKenna Rochford at: mckennanicole@rocotx.com

AUTHORIZATION*

This document is an agreement between you, your family, and the therapists at Roc OTx Pediatric Occupational Therapy. This document permits your therapist to treat your child and bill insurance. Please read it carefully and note any questions you might have so that they can be addressed prior to signing. Once you sign a copy for your child's file, it will constitute a binding agreement between you and the staff at Roc OTx Pediatric Occupational Therapy. You may revoke this agreement in writing or verbally at any time.

Clinical staff at Roc OTx Pediatric Occupational Therapy provide therapy assessments and treatments in home and community settings. All therapists are licensed in the state of Colorado and carry liability insurance.



Cancellations:

Please allow as much time as possible if you need to cancel your child’s appointment. If your child has a fever, contagious symptoms, such as coughing, sneezing, vomiting, or diarrhea, please cancel your therapy session by contacting your therapist as soon as possible. Children must be symptom-free for more than 48 hours prior to resuming therapy. By initialing below, you agree to the cancellation policies.

Initial: _____

Consent to Treatment:

I, _____, hereby authorize Roc OTx Pediatric Occupational Therapy to furnish information to insurance carriers concerning this treatment, and hereby irrevocably assign to the therapist all payments for therapy services rendered to me. I understand that I am financially responsible for all charges, regardless of whether they are covered by insurance. I am responsible for reasonable costs and/or attorney fees incurred for the collection of this account. Our policy is payment at the time of service. I understand that I must provide 24 hours' notice of cancellation for appointments and 2 weeks' notice for any vacations, or I may lose my appointment time and be placed on a waiting list.

Initial: _____

I have read this consent form and agree with the terms stated above.

Name (Printed):

Signature:

Date:



Photo/Video Release for ROC OTx Pediatric Occupational Therapy

Purpose of Use:

I, the undersigned, hereby grant permission for the use of photographs, videos, or other visual recordings of my child during occupational therapy sessions for the following purposes:

1. **Documentation:** For therapeutic purposes and progress tracking within the therapy provider's records.
2. **Educational/Instructional Use:** To assist in demonstrating techniques or methods used in therapy, which may be shared in training materials or educational contexts.
3. **Marketing/Promotional:** For advertising or promotional purposes, such as websites, social media, brochures, or newsletters.
4. **Research:** For use in research or case studies related to occupational therapy.

Permission:

- I understand that the photos/videos may be used in print, electronic, or online forms, and I consent to these uses.
- I acknowledge that my child's identity will be kept confidential unless otherwise specified in this release.
- I understand that no personal medical information will be disclosed without my consent.

Duration of Release:

- This consent is valid until revoked in writing by me.
- The photos/videos will be used for the duration of the therapy or as specified above.

Revocation of Consent:

- I understand that I have the right to revoke this consent at any time, in writing, and such revocation will not affect any actions taken prior to the revocation.



Parent/Guardian Consent:

By signing below, I acknowledge that I have read and understood this form and give my permission as indicated above.

Signature of Parent/Guardian:

Date:
