Patient, Parent, Caregiver Consent and Acknowledgement

Please initial each section and sign below.

_____ Consent *for Treatment*: I consent and authorize treatment/care, as determined to be necessary, by Therapeutic Innovations, Inc. I am aware that the practice of therapy is not an exact science and I understand that no guarantees have been made to me about the results of treatments or procedures. I acknowledge that therapy may be provided in areas not totally isolated from other patients and personnel.

_____ Notice *of Privacy Practices* is a complete description of the rights of patients at Therapeutic Innovations, Inc., with respect to patients' information and how patient information is protected. I have been given the opportunity to review the *Notice of Privacy Practices* prior to signing this Consent. I give permission to Therapeutic Innovations, Inc. to release information, in accordance the *Therapeutic Innovations, Inc. Notice of Privacy Practices*.

_____ *Financial Responsibility*: I consent and authorize Therapeutic Innovations, Inc. to apply, file, and receive all medical insurance benefits, private/ primary/ secondary or all other benefits, for any and all services rendered. I agree that I shall be jointly and severally financially responsible for any portion of the Therapeutic Innovations, Inc. invoice that is not paid, including but not limited to (i) deductibles, co-payments, (ii) any non-insured services, or (iii) any charges in excess of payment limitations imposed by third party payors. I understand that a $25.00 processing fee will be charged for a returned check from my banking institution, and that after 3 returned checks, all payments will need to be made by cash, money order, or credit card.

_____ *Digital Media and Electronic Communication*: I consent to digital media recordings (i.e., video, audio, photographs) and/ or electronic communication, including text and unencrypted emails, for the purposes of patient/parent/caregiver education, home exercise programs, treatment planning, diagnostic purposes, debt collection and/or internal training. If stored, the recordings will be located on password protected or encrypted company equipment.

_____ *No Show/ Cancellation Policy*: I acknowledge the understanding of the *No Show/ Cancellation Policy*. Therapeutic Innovations, Inc. requests that I give at least a 24-hour notice, when cancelling an appointment. Two no-shows and/or two or more late/unexcused cancellations within a calendar month will result in the patient being placed on a "floating status". This status requires that the patient/parent/caregiver call and reschedule future appointments. These appointments will be offered on a first come, first serve basis. Therapeutic Innovations, Inc. does not guarantee a specific therapist, when on a floating status.

_____ *Pediatric Patients*: I acknowledge that a parent/ caregiver must be present (i.e.in the waiting room), throughout the therapy session. However, if the patient is 10 years or older and has no behavioral issues, drop offs are allowed. In addition, I acknowledge that I am responsible for my child outside of the therapy session.

_____ *Rights and Responsibilities*: I acknowledge that I have been given the opportunity to review the *Therapeutic Innovations Patient Care Policy.*

_____ _____

Signature of Patient or Patient Representative Date

_____ _____

Printed Name of Signature Above Relationship to Patient