Thrive
Pediatric Therapy & Family Services
phone: (843) 839-9494 | fax: (843) 839-9544
1304 Azalea Court, Suite A Myrtle Beach, SC 29577
ThrivePediatricTherapySC@gmail.com
www.ThrivePediatricTherapySC.com

Consent Form/HIPAA Acknowledgement Form

I have been informed of the use and release of information collected through services received in regard to: _____(print patient's full name). I request that copies of information in regard to my child be released to/from:

1 _____ (Child's Doctor)
2 _____ (School/Daycare- if appropriate)
3 _____ (Other Doctors)
4 _____ (BabyNet -if appropriate)
5 _____ (Payer/Insurance)
6 _____ (ABA Company -if appropriate)
7 _____ (Other)
8 _____ (Other)

Please read and initial each of the following:

_____ I request that payment of authorized Medicaid and third-party payer's benefits be made to Therapy Consortium Inc. and Thrive Pediatric Therapy & Family Services LLC on my behalf for services furnished to me.
_____ I authorize Therapy Consortium Inc. and Thrive Pediatric Therapy & Family Services LLC to release any medical information about me that may be needed to determine these benefits payable for related services.
_____ I understand that I will not be billed for any Medicaid services furnished to me which were billed to Medicaid during the time I had Medicaid coverage for those services.
_____ I understand that Therapy Consortium Inc. and Thrive Pediatric Therapy & Family Services LLC are required by law to keep my health information safe. This information may include notes from your doctor/teacher/other health care providers, medical history, test results, treatment notes, and insurance information.
_____ Therapy Consortium Inc. and Thrive Pediatric Therapy & Family Services LLC have given me a copy of their privacy notice. I understand that they are required by law to give me a copy of their privacy notice and this notice tells me how my health information may be used and shared. It also tells me how I can look at and comment on my information.
_____ I consent to have my child treated by Thrive Pediatric Therapy & Family Services LLC for Speech Language Therapy Services and/or Occupational Therapy Services.
_____ I understand that Thrive Pediatric Therapy & Family Services LLC is a teaching facility and student clinicians will be observing and treating patients.

Parent/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Thrive
Pediatric Therapy & Family Services
phone: (843) 839-9494 | fax: (843) 839-9544
1304 Azalea Court, Suite A Myrtle Beach, SC 29577
ThrivePediatricTherapySC@gmail.com
www.ThrivePediatricTherapySC.com

Annual Update Form

Today's Date: _____ Child's Name:_____
Child's Date of Birth: _____ Child's Age: ____years ____months. Child's Sex:_____

Name of School: _____ Grade:_____
Does your child receive therapy services at school? Please list therapy type and therapist name(s): _____

_____
Does your child attend ABA Therapy ___Yes___No ABA company name: _____
Does your child receive private therapy outside of this clinic?___Yes___No List type, therapist name(s) and company name(s): _____

New diagnosis(es) (list type and dates): _____
New evaluations (list type and dates): _____
Treatments/hospitalizations/surgeries in the past years: _____

_____
Current medications (list name and dosage): _____
Pediatrician Name _____ Group/Practice Name: _____
Other physicians:
Name _____ Group/Practice Name: _____
Name _____ Group/Practice Name: _____
Name _____ Group/Practice Name: _____

What are your concerns about your child? _____
What do you hope will be gained by continuing therapy at this clinic? _____

_____

_____

Please list any changes in your family structure that have occurred in the past year. (new spouse, divorce, custody issues, deaths, births, etc.): _____

_____
Please explain any other changes that have occurred in the past year: _____

_____