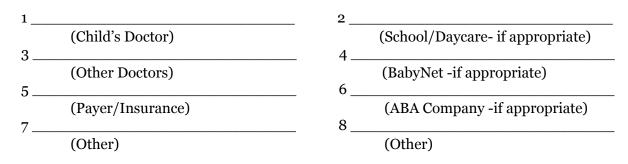


phone: (843) 839-9494 | fax: (843) 839-9544 1304 Azalea Court, Suite A Myrtle Beach, SC 29577 ThrivePediatricTherapySC@gmail.com www.ThrivePediatricTherapySC.com

## **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:



## 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:		



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## Annual Update Form

Today's Date:	Child's Name:_					
Child's Date of Birth:						
Name of School:				Grade:		
Does your child receive therapy s	ervices at school? Please list	therapy ty	pe and thera	pist name(s):		
Does your child attend ABA Thera						
Does your child receive private the company name(s):						
New diagnosis(es) (list type and d	ates):					
New evaluations (list type and dat						
Treatments/hospitalizations/surg						
Current medications (list name a						
Pediatrician Name	Group/Practic	e Name:				
Other physicians:						
Name	Group/Practic	e Name:				
Name	Group/Practice Name:					
Name						
What are your concerns about yo	ur child?					
What do you hope will be gained	by continuing therapy at this	s clinic?				
Please list any changes in your far custody issues, deaths, births, etc	mily structure that have occu	irred in the	e past year. (	new spouse, divorce,		
Please explain any other changes	that have occurred in the pa					