Alaska Pediatric Therapy

Consent for Treatment/Release of Information and Billing

I, _____Parent/Guardian of _____

Authorize the release of written and verbal information pertaining to my child's physical therapy and medical program To and From: Alaska Pediatric Therapy, LLC and the following persons and agencies:

Initials

- Insurance Company: _____
- Pediatrician: _____
- Infant Learning Program _____
- Other Therapists/School etc. _____

Signature: _____ Date: _____

I understand that my child's records may be reviewed by state representatives for the purpose of Medicaid/Medicare certification or by therapists or pediatrics for the purpose of professional peer review.

Signature: _____ Date:_____

I authorize payment of insurance/Medicaid benefits directly to Alaska Pediatric Therapy, LLC:

Signature: _____ Date:_____

I agree to pay my portion of the insurance deductible directly to Alaska Pediatric Therapy, LLC:

Signature: _____ Date: _____

I give Alaska Pediatric Therapy, LLC permission to submit bills directly to the insurance carrier.

Signature:_____Date:_____

Should collections become necessary, I agree to pay all collection agency fees.

Signature:_____Date:_____