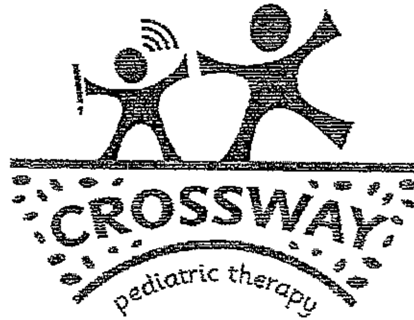

Consent and Authorization for Services and Treatment

- **Consent for Treatment**
  This patient or legal guardian gives consent for procedures and treatment as ordered by a physician or developmental evaluation center. I understand and agree that Crossway, Inc. will not be liable in the event that scheduled services cannot be provided as requested, or when insufficient notice is given concerning canceled services.

- With this consent, Crossway, Inc. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist in the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items, and any calls pertaining to clinical care.

- With this consent, Crossway, Inc. may e-mail to my home or other alternative location in reference to any items that assist in the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items, and any calls pertaining to clinical care.

- **Patient Acknowledgement**
  I acknowledge by signing below that I have received a copy of the Notice of Privacy Practices.

- **Authorization to Release**
  This patient or legal guardian consents to the release of information by a school, hospital, physician, developmental evaluation center, or other agency where child was evaluated to Crossway, Inc. I also authorize Crossway, Inc. to disclose all or part of my medical information to any agency to benefit my care.

- **Private Insurance**
  This patient or legal guardian agrees to authorize direct payment of insurance benefits by insurance carrier to Crossway, Inc. I understand that if my insurance carrier does not accept "assignment of benefits", I am obligated to endorse and send payments to Crossway, Inc. I understand that Crossway, Inc. is enrolled as an in-network provider with Aetna, Blue Cross Blue Shield and Medcost, North Carolina and and South Carolina Medicaid.

- **Medicaid**
  This patient or legal guardian verifies that the information given for payment under Title XIX (Medicaid) Act is correct. Also, authorizing the release of all records required acting on this request so that payment of authorized benefits is made on his/her behalf to Crossway, Inc.

- **Client Financial Responsibility**
  With this consent, Crossway, Inc. may verify insurance coverage for Occupational, Physical and Speech Therapy services. I understand that verification of benefits is not a guarantee of payment and I understand that if payment is not made to Crossway, Inc. by other payers, I will be responsible for the services rendered to my child. This payment will be made dependent upon a written notice. I understand that I am responsible for insurance deductibles and amounts not covered by any insurance or payment provider.
  THIS DOES NOT INCLUDE MEDICAID RECIPIENTS. MEDICAID RECIPIENTS ARE REQUIRED TO MAINTAIN ACTIVE MEDICAID STATUS, BUT CAN NOT BE BALANCE BILLED FOR UNPAID CLAIMS.

- **Notification of Change**
  This patient or legal guardian agrees to notify Crossway, Inc. within 24 hours of any information change it receives regarding changes in Insurance, Medicaid, or other funds that affect the reimbursement.

- **Private Pay Clients**
  Families who are private pay clients are asked to pay for the evaluation and/or the initial therapy session at the time services are rendered. After that point, you will receive a monthly bill.

Attendance and Cancellation Policy

- Due to the demand for OT and ST, appointment cancelled with less than 24-hours notice and not rescheduled will result in a cancellation fee of $55. Repeated cancellations may result in either forfeiture of permanent appointment or termination of service. Failure to contact the office prior to appointment time will be a no show and a full fee-for-service may be charged. Cancellation fees are not reimbursed by insurance companies or Medicaid and will be billed to the responsible party.

  If a parent or guardian cancels 50% of the sessions for two consecutive months or has 3 no shows, Crossway, Inc. reserves the right to discontinue services with the family allowing them to find another direct service provider for therapy services.

Signature (Parent/Legal Guardian)	**Relationship to Client**	**Date**
Signature (Witness)	**Client's Name**	**Date**