NEURODEVELOPMENTAL THERAPY SERVICES

Consent to Use and Disclosure of Protected Health Information Client Acknowledgement Form

Use and Disclosure of Your Protected Health Information4

Your protected health information may be used by Neurodevelopmental Therapy Services or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Policies and Procedures

Our "Notice of Privacy and Procedures" provides information about how we may use and disclose protected health information (PHI) about you. As stated in our "Notice of Privacy Policies and Procedures", the terms of our notice may change at any time. You should review the "Notice of Privacy Policies and Procedures" for a more complete description of how your protected health information may be used or disclosed.

Signature

I acknowledge I have been offered or have received a copy of our "Notice of Privacy Policies and Procedures".

I have reviewed this consent form and give permission to Neurodevelopmental Therapy Services to use and disclose my information in accordance with it. I consent for treatment at Neurodevelopmental Therapy Services. I authorize payment of medical benefits made to Neurodevelopmental Therapy Services for services furnished to me.

I agree and understand that my minor child or I may be treated and discussed in an open concept with other clients and/or parents present. I further understand that should I elect to have treatment or discussion in a closed environment, Neurodevelopmental Therapy Services will make every attempt to provide this service.

NTS maintains relationships with educational institutions across the country by allowing students to complete fieldwork assignments at our facilities. Your child may be observed or provided supervised treatment as part of the educational process from the Universities. If your child is chosen to participate with a graduate student, a detailed information and permission packet will be provided and discussed.

Payment is due at the time services are rendered. As a courtesy, or as a contracted provider, Neurodevelopmental Therapy Services will gladly file my insurance claim. Benefits are determined by the contract between me as a covered member, and my insurance company. I understand that payment for services does ultimately remain my responsibility.

_____ _____

Name of Client (Print) Signature of Client Representative

_____ _____

Signature of Client/Guardian Relationship of Client Representative

Date:_____