4483-A Forbes Blvd, Lanham, MD 20706 or 1526 Howard Rd, SE Washington, DC 20020*Phone: 240-479-6769 * Fax: 1888-242-8040

Consent for Care and Treatment

I, the undersigned, do herby agree and give my consent for Paradigm Therapy Partners to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.

Parent/Guardian/Responsible Party_____ Date_____

Benefit Assignment/Release of Information

I, herby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payors to ***Paradigm Therapy Partners***. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Parent/Guardian/Responsible Party_____ Date_____

Financial Policy Statement

We bill your invoice carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangement for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full form you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to you insurance company. In the event your company establishes an internal usual and customary fees schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Paradigm Therapy Partners.

The above may not apply for those patients that are considered Workers Compensation or who have benefits with a balance billing contract, such as and HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be responsible for the total amount of charges for services rendered to you.

Paradigm Therapy Partners verifies benefits as courtesy to you. However, Paradigm Therapy Partners does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans.

When you pay by check, you expressly authorize ***Paradigm Therapy Partners***, if your check is dishonored or returned for any reason, to be charged to your account. You will be responsible for the amount of the check plus a returned check fee of $37.00.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed, including court cost, collection agency fees, and attorney fees.

Information Privacy: ***Paradigm Therapy Partners*** will use and disclose your personal health information to treat your, to receive payment for the care we provide and for other health care operations. Health care operation generally include those activities we perform to improve the quality of care. We have prepared a detailed of NOTICE OF PRIVACY PARACTICES to help you better understand our policies in regards to your personal health information. The terms of this notice may change with time and we will always post the current notice on our website and have copies available for distribution. The undersigned acknowledges receipt of the information.

I, the undersigned:

( ) have insurance coverage by _____, and authorize direct payments from my insurance carrier to ***Paradigm Therapy Partners***. Note: you are responsible for knowing your coverage benefits. ***Paradigm Therapy Partners*** will make every effort to inform you if a supply or service is not covered by your insurance.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

Parent/Guardian/Responsible Party Date