Ancient City Children's Therapy, LLC
910 S. Winterhawk Dr. # 107
St. Augustine, Fl. 32086
(904) 826-7886

Consents and Acknowledgement

Client: ____

DOB: _________________________

Consent for Treatment: I hereby give my permission for a representative of ANCIENT CITY CHILDREN'S THERAPY, LLC. to provide services to me and/or to my dependent.

Consent for Emergency Treatment: I hereby give permission to ANCIENT CITY CHILDREN'S THERAPY, LLC. to seek emergency medical treatment for me and /or my dependent by a hospital and /or physician in the case of an emergency and I understand that protected health information may disclosed at that time.

Consent for Billing of Medicaid and/or Third Party Reimbursement Party: I hereby give ANCIENT CITY CHILDREN'S THERAPY, LLC. permission to bill Medicaid and /or my third party reimbursement party for charges pertaining to me and /or my dependent for evaluation and treatment. I assign benefits to ANCIENT CITY CHILDREN'S THERAPY, LLC. I assume financial responsibility for any balance due including co-pays, co-insurance and balance not paid by my insurance. Participants of the Infant Toddler Program are subject to financial responsibility according to the sliding fee scale.

This consent is valid from the date a signature is obtained until date of discharge from ANCIENT CITY CHILDREN'S THERAPY, LLC . However, the consent is subject to revocation at any time except to the extent that action has been taken in reliance on the consent.

I was offered to receive and/or had explained to my understanding the Client's Rights and Responsibilities and the HIPPA Privacy Practices. I declined/accepted their receipt.

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Signature of client and/or legally responsible person/ Relationship to client

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Date