MINOR PATIENT INFORMATION		
Name		**Date of Birth**:
Primary Mailing Address		
	PRIMARY Household	**SECONDARY Household** *(if applicable)*
Parent/Guardian Name(s)		
Mailing Address		
Home Phone		
Addl' Phone#'s	**Cell**:	**Cell**:
	Work:	**Work**:
Email Address		
Insurance (if covered under plan)	**Insurance Provider**:	**Insurance Provider**:
	Policy Holder:	**Policy Holder**:
	DOB or SSN:	**DOB or SSN**:
	Employer:	**Employer**:

PARENT/GUARDIAN AUTHORIZATION FOR TREATMENT of MINOR PATIENT

To facilitate Physical Therapy treatment of my child *(name)* ____ ("**Minor Patient**") by Cornerstone Physical Therapy licensed staff, the undersigned parent or legal guardian of the **Minor Patient** agrees as follows:

1. I am a parent/legal guardian of the **Minor Patient** authorized to make health care decisions on behalf of the **Minor Patient**,
2. I authorize Cornerstone Physical Therapy to:
   a. provide Physical Therapy treatment in my absence, which allows a **Minor Patient** to come to appointments unaccompanied by a parent/guardian/parent substitute *(see #3)*
   b. authorize a Parent Substitute designated by me *(see #3)* to give informed consent for emergency, urgent, and other medical care and treatment for the **Minor Patient**. To ensure that the Parent Substitute *(designated below)* has access to Protected Health Information needed to make informed consent decisions, I authorize Cornerstone Physical Therapy to provide the Parent Substitute with Protected Health Information relating to the **Minor Patient**. "Protected Health Information" means all medical records and treatment records relating to the **Minor Patient** which are protected and confidential under 42 C.F.R. Part 2, Wis. Stat §51.30 and 146.82, the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPPA) and the Standards for Privacy of Individually Identifiable Health Information (HIPAA Privacy Regulations), 45 C.F.R. Part 160 and Part 164, subparts A and E.
3. **Identification of Parent Substitute**. I appoint the following Parent Substitute(s) to obtain access to Protected Health Information, give informed consent for care and treatment, or otherwise receive custody of the **Minor Patient**. This authorization is valid for a maximum period of two (2) years from date signed, unless a shorter duration is specified. This authorization may be revoked at any time prior to that expiration date by providing Cornerstone Physical Therapy with written notification.

Parent Substitute(s)	Relationship to Minor	Phone Number

4. I agree to release Cornerstone Physical Therapy from liability for any claims resulting from Cornerstone Physical Therapy's provision of patient care and release of Patient Health Information in reliance upon this authorization.

I have carefully read and considered this consent form before signing it.

______________________________________ ____________________

Signature of Legal Parent/Guardian *Date*

Please read each section below and sign at the bottom of the form.

CANCELLATION POLICY

As a courtesy to our staff and other patients, we ask that you provide a **24-HOUR** notice if your child is unable to keep his/her scheduled appointment. After **3 cancellation/no-show** occurrences, we reserve the right to review this case and determine discharge as appropriate.

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding protected health information for my child. I understand this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers directly to Cornerstone Physical Therapy
- Conduct normal healthcare operations such as quality assessments and physician certifications
- I understand if payment by my insurance company is disputed or delayed, I am responsible for the payment of services rendered

I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this content in writing at any time, except to the extent that you have taken action relying on this content.

I authorize CORNERSTONE PHYSICAL THERAPY to bill my insurance carrier and receive payment directly from the insurance carrier(s).

I also provide consent for Cornerstone Physical Therapy to provide direct treatment to my child as advised by his/her treating clinician.

PAYMENT POLICY

DEDUCTIBLE: A minimum payment of $50.00 is required **per visit** if your deductible has not been met for the calendar year.

CO-INSURANCE: Co-insurance refers to the percentage the policy holder is required to pay toward this medical bill. Weekly payments may be made toward co-insurance obligations.

CO-PAY: The dollar amount the policy holder is required to pay in full each visit.

IT IS CORNERSTONE PHYSICAL THERAPY'S OBLIGATION TO COLLECT FEES FOR DEDUCTIBLES AND CO-PAYS PER INSURANCE CONTRACT AT THE TIME OF SERVICE.

I have read and understand my insurance policy. I understand it is my obligation to know what my insurance does and does not cover. It is also my responsibility to know if my insurance has deductible, co-insurance or co-pay requirements.

Patient Name: ____

Parent/Guardian Signature: ____________________________________ **Date**: ____________________