CLIENT'S NAME: _____ CLIENT'S BIRTHDATE: _____

PARENT/GUARDIAN: _____

PHONE: _____ EMAIL: _____

☐ I give consent for A to Z Therapies, LLC to provide assessment and ongoing **Developmental Special Instruction** (DSI) services. DSI services are paid for by the Division of Developmental Disabilities. DSI services are not billable to insurance. They are "State-Only" funded by the Division.

☐ Client is DES/DDD eligible and/or ALTCS eligible. Services for children under 3 may require a share or cost, calculated by DES.

☐ I give consent for A to Z Therapies, LLC to provide evaluation and ongoing therapy services. I understand that evaluation results, therapy recommendations and daily notes are available to me upon my request. Services which may be provided are **Occupational Therapy, Physical Therapy, and/or Speech Language Pathology.**

☐ Bill Primary Insurance

Policyholder Primary Information: ☐ None

Insurance Company: _____

Name of Policyholder: _____

Policy Number: _____

Effective Date: _____

DOB of Policyholder: _____

Group Number: _____

Address of Insurance _____

Phone Number: _____

☐ Bill Secondary Insurance

Policyholder Secondary Information: ☐ None

Insurance Company: _____

Name of Policyholder: _____

Policy Number: _____

Effective Date: _____

DOB of Policyholder: _____

Group Number: _____

Address of Insurance: _____

Phone Number: _____

☐ I understand that I may be responsible for any portion insurance does not pay up to the private pay rate, including deductibles and cancellations if client's services are not covered by DDD.

☐ **PRIVATE PAY**

Payment is due at the time services are rendered. ACH services are available. Contact billing office. The fee schedule is as follows: Therapy visits are $85.00 per session, evaluations are $250.00 and cancelled visits are $40.00. Group sessions, per fee schedule.

☐ I understand that when a 24 hr. notice is not provided to the therapist/DSI, in order to avoid travel, I will be charged for a cancelled visit. Forward any questions to the billing department at 602.439.7400 or referrals@atoztherapies.com

☐ I authorize _____ visits per _____

☐ I give permission to A to Z Therapies, LLC and its employees to contact my child's physician to discuss therapies and obtain physician's orders for therapy evaluation and treatment. I understand a current prescription is required to provide therapies.

Child's Physician: _____ Clinic: _____

Phone #: _____ FAX #: _____

☐ I authorize the release of information for exchange between A to Z Therapies, LLC, and the physician's office, DES/DDD and school as they apply to the provision of services.

☐ I authorize the release of all information in order to process claims for services. I authorize direct payment to A to Z Therapies, LLC. Explanation of Benefits and payments received from insurance company to the consumer will be forwarded to A to Z Therapies, LLC upon receipt.

_____ _____

Signature of Parent/Guardian Date