RISE Pediatric Therapy LLC
5610 Ward Road Suite 300
Arvada, CO 80002
Phone 720-602-0384 Fax 720-302-2932

Patient Name: _____ SOC Date: _____

Consent for Treatment

I consent and authorize RISE Pediatric Therapy LLC ("the Agency"), it agents and associates to provide care and treatment to me in my home as prescribed by my physician and per agency policy. I understand that I am required to have an attending physician at all times and that my plan of treatment may change depending on my physician's orders. I have received an explanation of the services that will be provided to me, including disciplines and proposed frequency of visits, and understand that I have the right to participate in developing my plan of care. The initial services are as follows:

Physical Therapy Frequency and Duration: _____
Occupational Therapy Frequency and Duration**:** _____
Speech Therapy Frequency and Duration: _____

Authorization for Release of Information

I hereby consent and authorize the Agency to release and receive information for the purposes of treatment, payment, and health care operations. The exchange of information may occur between, but is not limited to, physicians, third party payers, other health providers, and regulatory and/or accrediting reviewers.

Statement to Permit Payment for Home Health Services

I hereby request that payment of authorized medical home health services be made on my behalf to the Agency.

I understand that agency will bill ☐ Medicaid ☐ Insurance Co.: _____
☐ Patient for the services being provided to me by the Agency. I understand that I will be responsible for the following amount._____

Acknowledgements

I have received verbal and written information on the following, and have had the information explained to me:

1. Patients' Bill of Rights
   a. Including receipt of the Agency complaint process and the state toll free hotline number.
2. Home Health Care Patient Handbook
   a. Including agency contact information to include emergency and after hours.
3. Notice of Agency Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by the Agency and my rights with respect to my health information.
   a. I acknowledge that I have been provided with the opportunity to discuss concerns regarding the privacy of my health information.
4. OASIS Statement of Privacy Rights for patient's over the age of 18
5. Agency Disclosure Notice
6. Emergency Preparedness, Infection Control and Safety Education

Advance Directives

I have an Advance Directive ☐ Yes ☐ No
If yes, I have the following ☐ Living Will ☐ Medical Durable Power of Attorney ☐ Do Not Resuscitate Order
Other Advanced Directives ☐ Yes ☐ No Explain
I have requested and received more information _____
I certify that I have read and agree with the information on this document and have been provided a copy for my records. I have participated in the formation of my plan of care.

_____ _____
Patient Signature or responsible party *Date*

_____ _____
Witness Signature *Date*