Pediatric Occupational and Physical Therapy
154 S. Livingston Avenue · Suite 204 · Livingston · NJ 07039 · (973) 535-5010 · www.pediatricpotentialsnj.com

PEDIATRIC POTENTIALS POLICIES

CONSENT FOR TREATMENT OF A MINOR

Being the parent/legal guardian of_____ (minor's printed name) I _____, (parent/legal guardian) hereby authorize the physical and/or occupational therapists at Pediatric Potentials to perform appropriate assessment and treatment procedures of the minor listed above. This consent form can only be revoked by written notification by the parent/guardian.

_____ _____

Parent/Guardian Signature Date

CANCELLATION POLICY

Consistency and reliability of appointments is extremely important. To accommodate you and your child's schedules as well as that of the staff of Pediatric Potentials, we ask that you please review and adhere to our policy.

If you need to cancel your child's appointment due to illness, please do so at least 24-hours in advance to avoid a cancellation fee of $50. When in doubt about your child's health, we prefer that you reschedule rather than bringing in your sick child (or siblings). Please respect our request that your child or sibling be fever free for 24-hours before coming into the office. If you need to cancel your child's appointment due to travel or other conflicts, please do so as far in advance as possible. If your child is absent from therapy 25% of the time or more, or for four or more consecutive sessions, or there is an extended pattern of non-attendance, therapy will be discontinued unless special arrangements are discussed in advance. Please call, text or email your therapist directly in order to cancel.

Client Name: _____

_____ _____

Parent/Guardian Signature Date

FINANCIAL & INSURANCE POLICY

We conduct business on a fee for service basis. Payment is expected at the time of your child's visit either by credit card, check or cash. Each month you will receive an emailed superbill to submit to insurance. Pediatric Potentials is an out-of-network provider. We will do our best to help facilitate reimbursement, but the financial responsibility is yours. We do not bill insurance or accept payment directly from your insurance provider.

By signing below, you acknowledge that you agree to Pediatric Potential's financial and insurance policy and that it is your responsibility to do your due diligence in communicating with the insurance company if you choose to submit for reimbursement.

Your signature below recognizes agreement with the payment and insurance policy as well as affirms that you've been told the rates for services.

Client Name: _____

_____ _____

Parent/Guardian Signature Date

Thank you for your compliance with these policies. Should you have any questions please reach out to our office.

Shoshana Newman, PTDirector Tax ID: 46-1226672