

New Patient Consent & Policy Forms



This packet includes important documents required for evaluation and ongoing therapy services. Please review and complete all sections before or at your first visit.

Included Documents:

1. Consent for Evaluation & Treatment
2. Notice of Privacy Practices (HIPAA)
3. Photo & Video Media Consent (optional)
4. Attendance & Cancellation Policy
5. Financial Policy
6. Clinical Policies
7. Clinical Policies pt 2
8. Acknowledgement of Intake Packet (Signature Page)



Consent for Therapy Evaluation and Treatment

Effective Date: May 16, 2026

I, the undersigned parent/guardian, authorize **Next Level Pediatric Therapy, LLC** to provide physical therapy evaluation and treatment for my child/ward as deemed necessary and appropriate for their condition.

I understand that services may include, but are not limited to, therapeutic exercise, neuromuscular re-education, gait and balance training, functional mobility training, developmental skill activities, and other skilled interventions within the scope of physical therapy practice.

I understand that treatment is individualized based on clinical assessment and may be modified as clinically indicated by the treating therapist.

I acknowledge that physical therapy is intended to improve functional abilities; however, no specific outcomes can be guaranteed.

I understand that I may refuse or discontinue services at any time without penalty.

I consent to the use and disclosure of protected health information as necessary for treatment, payment, and healthcare operations in accordance with HIPAA requirements.

By signing below, I confirm that I have read, understand, and voluntarily consent to physical therapy services for my child/ward.

Patient Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Relationship to Patient: _____





Notice of Privacy Practices

Effective Date: May 16, 2026

We are required by law to protect your child's health information (Protected Health Information or PHI). This Notice explains how we may use and share it and your rights.

1. Uses and Sharing of Health Information

- We may use or share PHI to provide treatment, bill insurance (including Medicaid), operate our clinic, meet licensing/credentialing requirements, and comply with laws or audits.
- We may share information with healthcare providers, insurance companies, schools/care teams (when appropriate), and government or oversight agencies when required by law.

2. Your Rights

- Access or obtain copies of records
- Request corrections
- Request restrictions (may not always be approved)
- Request confidential communication methods
- Receive a paper copy of this Notice
- Request an accounting of certain disclosures

3. Our Privacy Protections

We safeguard PHI through secure systems, staff training, and physical and administrative protections.

4. Required and Permitted Disclosures

We may disclose PHI without written authorization when required by law, including public health reporting, legal proceedings, insurance billing, and audits (including Medicaid). We are also required to notify you if a breach of unsecured PHI occurs.

6. Complaints

If you believe your privacy rights were violated, contact us or file a complaint with the U.S. Department of Health and Human Services (HHS). You will not be penalized.

Parent/Guardian Signature: _____ **Date:** _____



Photo and Video Consent Form

I hereby give permission to **Next Level Pediatric Therapy** and authorized clinical providers to capture photo and/or video recordings of my child during therapy sessions.

These recordings may be used only for the purposes selected below.

CLINICAL USE (TREATMENT PURPOSES)

- ☐ Video/photo used for home exercise program development and instruction
- ☐ Video/photo used for gait analysis and movement assessment
- ☐ Video/photo used for clinical documentation and progress tracking
- ☐ Video/photo used for interdisciplinary care coordination

INTERNAL TRAINING

Internal staff training and clinical education

- ☐ Development of training materials, modules, and case examples
- ☐ Professional presentations and education for approved clinical organizations

EXTERNAL USE

- ☐ Social Media (Facebook, Instagram)
- ☐ Marketing and promotional materials (print and digital)
- ☐ Outside professional training/educational events
- ☐ Research and/or publications (de-identified when possible)

ACKNOWLEDGEMENTS

- No identifying information (such as full name) will be intentionally included unless separately authorized
- Media will only be used for the purposes selected above
- This consent is voluntary and may be revoked in writing at any time; however, previously created or distributed materials cannot be recalled
- Services are not conditioned on signing this consent

Parent/Guardian Signature: _____ **Date:** _____



Attendance and Cancellation Policy

1. Attendance Requirement

Regular attendance is required for continued medically necessary services. A minimum of **75% attendance of scheduled visits within a rolling 12-week period** is expected to support progress toward goals. Attendance below this level, or patterns of missed visits, cancellations, or inconsistency, may result in schedule modification, increased monitoring, removal from a recurring schedule, or discharge if consistent participation cannot be maintained.

2. Cancellations

A minimum of 24-hour notice is required for cancellations. Late cancellations (less than 24 hours) will be documented in the medical record.

3. Late Cancellations & No-Shows

Late cancellations (less than 12 hours) and no-shows (failure to attend without notice) may be subject to a **\$35 fee**. Two (2) or more no-shows within 12 weeks may result in discharge or transition to a call-in schedule.

4. Late Arrival

Arrival more than 15 minutes late may result in cancellation of the session at the therapist's discretion and may be documented as a missed visit.

5. Caregiver Presence / Pick-Up

Caregivers must remain on-site unless otherwise approved by the therapist. If excused, caregivers must return at least 10 minutes prior to session end time. Noncompliance may affect scheduling or continuation of services.

6. Clinic Cancellations

Clinic cancellations due to provider absence, illness, weather, or facility closure will not count against attendance. Make-up sessions are offered based on availability.

7. Schedule Retention

Standing appointment times are not guaranteed and may be modified or removed based on attendance patterns or clinical necessity.

8. Discharge for Non-compliance

The clinic reserves the right to discharge patients for repeated missed visits, noncompliance with attendance policies, or inability to maintain an effective plan of care.

Parent/Guardian Signature: _____ Date: _____



Financial Policy

Payment for services is required in accordance with insurance participation and clinic policies. This policy applies to all patients regardless of insurance coverage.

1. Insurance Coverage

Verification of insurance benefits is not a guarantee of payment. Patients/guardians are responsible for any services not covered by Medicaid or other insurance plans.

2. Medicaid Coverage

Services must meet medical necessity requirements as determined by Medicaid guidelines. If services are denied, reduced, or not covered, the patient/guardian is financially responsible for non-covered services where applicable under Medicaid policy.

3. Co-Payments / Patient Responsibility

If applicable, all co-pays, deductibles, or patient responsibility amounts are due at the time of service unless other arrangements are approved in writing.

4. Non-Covered Services

Services determined not medically necessary, not covered, or exceeding benefit limits are the financial responsibility of the patient/guardian.

5. Missed Appointment Fees

Late cancellations and no-show appointments may result in a **\$35 fee per occurrence**, as outlined in the Attendance Policy. These fees are not billable to insurance.

6. Payment Responsibility

The responsible party on file agrees to pay all balances incurred for services rendered. Accounts with unpaid balances may result in suspension or discontinuation of services.

7. Billing Accuracy

The patient/guardian is responsible for providing accurate and up-to-date insurance and billing information. Failure to provide accurate information may result in denied claims and patient responsibility for charges.

8. Collection of Payments

Outstanding balances may be subject to standard collection procedures if not resolved within clinic billing timelines.

Parent/Guardian Signature: _____ **Date:** _____



Clinical Policies

Next Level Pediatric Therapy provides therapy services in a safe, structured, and supportive environment. We recognize that children have diverse developmental, sensory, communication, and behavioral profiles. These policies are designed to support consistent, individualized, and medically necessary care.

By receiving services at Next Level, families acknowledge and agree to the following.

1. Medical Necessity & Plan of Care

Services are based on individualized evaluation and a therapist-developed plan of care. Therapy is medically necessary and reviewed regularly to ensure it continues to meet the child's needs. Frequency, duration, and goals may be adjusted based on progress, participation, and clinical need.

2. Progress & Continuation of Care

Continued services are guided by:

- Progress toward individualized goals
- Participation and engagement in therapy sessions
- Family support of recommended home strategies
- Ongoing medical necessity

If a child is not making expected progress or is unable to meaningfully participate due to inconsistent attendance or other factors, the plan of care may be adjusted or services may be paused or discontinued as clinically appropriate.

3. Caregiver Participation

Caregiver involvement is a key part of pediatric therapy and may include:

- Observation or participation in sessions as appropriate
- Carryover of home-based strategies and activities
- Sharing updates related to medical, behavioral, or developmental changes

Caregiver collaboration helps support carryover of skills across environments.

4. Safety, Behavior & Shared Clinic Environment

Next Level Pediatric Therapy maintains a safe, structured, and supportive environment for all children. We recognize and support a wide range of sensory, developmental, and communication needs.



To support all patients receiving care:

- Families are expected to support respectful and safe behavior in shared clinic spaces
- The clinic environment may include varying levels of noise, movement, and vocalizations related to other children's therapeutic needs
- Vocalizations, sensory responses, or movement-based regulation strategies may be part of a child's therapy experience
- Staff may gently redirect, pause, or modify sessions to support safety and engagement
- If behavior becomes unsafe or significantly limits the ability to participate in therapy, staff may recommend a break or temporary relocation

Next Level provides reasonable accommodations to support individual needs while maintaining a safe and effective therapeutic environment for all children.

5. Siblings & Additional Children

Siblings and non-participating children should remain in designated areas unless approved by clinic staff. Caregivers are responsible for supervision of all non-participating children at all times. Staff may request that additional children remain in waiting areas to support safety and focus during therapy sessions. Next Level is not responsible for their supervision or safety.

6. Communication Policy

Next Level is committed to clear, consistent, and secure communication.

- All communication must occur through approved clinic channels (clinic phone number and/or secure patient portal)
- Personal phone numbers, emails, and social media accounts may not be used to contact staff for clinical matters
- Messages sent outside approved channels may not be received or responded to
- This policy supports privacy, consistency of care, and HIPAA compliance

7. Discharge Criteria

Services may be discontinued when:

- Individualized therapy goals are met
- Medical necessity is no longer present
- Attendance or participation does not support effective service delivery
- Family requests discharge
- Services are no longer clinically appropriate based on professional judgment

Parent/Guardian Signature: _____ **Date:** _____



Acknowledgment of Intake Packet & Consent

Patient Name: _____

Parent/Guardian Name: _____

Date: _____

By signing below, I acknowledge that I have received, read, and understand the following documents provided by Next Level Pediatric Therapy:

- Consent for Evaluation and Treatment
- Notice of Privacy Practices (HIPAA)
- Photo & Video Media Consent (if signed)
- Attendance & Cancellation Policy
- Financial Policy
- Clinical Policies

I understand that these documents outline the expectations, policies, and procedures related to my child's care, including treatment participation, attendance requirements, financial responsibility, privacy practices, and clinic operations.

I understand that:

- Therapy services are based on medical necessity and individualized plans of care
- Continued services may be adjusted based on progress, participation, attendance, and clinical judgment
- The clinic maintains policies to support safety, consistency, and appropriate use of services
- I am responsible for reviewing and complying with all outlined policies
- I may request clarification at any time regarding any policy or consent

I understand that participation in services is voluntary and that I may withdraw from services at any time.

Parent/Guardian Signature: _____

Date: _____

