www.atozpediatrictherapy.com

2026 CONSENT FORM

Name of Child: _____ Date of Birth: _____

I, _____, hereby consent to the Evaluation, Treatment, and insurance billing for my child. The Evaluation may include: observation of the child; formal and informal testing; follow up visits; and ongoing intervention. I understand that the results of the Evaluation and the Plan of Care will be shared with me. I agree to comply with the Plan of Care to the best of my ability for the best outcome for my child. I understand that at any given time I have the right to refuse care and revoke my consent for treatment with A to Z Pediatric Therapy/ABA to Z, LLC.

I consent to and assume all risks, hazards of, and incidental to the participation of the above named child in the activities of A to Z Pediatric Therapy/ABA to Z, LLC, and agree to indemnify the said Organization and its officers, servants, or agents nominated or appointed by or on its behalf against all loss from any claim hereafter made against it, them or any of them by or on behalf of said child and arising directly or indirectly from such participation.

A to Z Pediatric Therapy/ABA to Z, LLC deem it their responsibility to provide effective and quality treatments to their families in a safe environment. If a therapist feels that a situation is unsafe for them personally, A to Z Pediatric Therapy/ABA to Z LLC, reserves the right to discontinue services.

A to Z Pediatric Therapy/ABA to Z, LLC has an obligation and responsibility to their professional guidelines and standards of practice. Therefore, when a child no longer qualifies for services or therapy is no longer effective or productive for various reasons, a Discharge Summary will be completed. It is the right of the caregiver at any time for any reason to request a change in providers. However, A to Z Pediatric Therapy and ABA to Z, LLC. cannot guarantee that a change request will be granted.

SESSION PARTICIPATION AND CANCELLATION POLICY:

_____I agree to actively participate in the scheduling of my child's session and understand that unscheduled absences may result in a discharge from therapy services. In addition, I agree to be available to assist my child's therapist regarding sessions; in compliance with the Plan of Care; and following the home program under the direction of my child's therapist.

INSURANCE AND PAYMENT POLICY CONSENT:

_____I authorize A to Z Pediatric Therapy/ABA to Z, LLC through their third-party billing company, Boost Practice Intelligence, to submit claims to my insurance company on my behalf and authorize my insurance company to pay benefits as well as release the explanation of benefits to A to Z Pediatric Therapy/ABA to Z, LLC. In the event that any therapy service is not covered by my private insurance and no additional insurance is active such as Medicaid, I am financially responsible for any balance due.

_____I understand that I must notify A to Z Pediatric Therapy/ABA to Z, LLC immediately should there be a change in insurance or personal information. Failure to do so will result in my responsibility for payment of services if insurance denies services due to lack of authorization and/or verification of benefits.

_____I understand that verification of benefits does not guarantee payment of services and I am financially responsible for any balance due.

_____I authorize my insurance and Medicaid benefits to be paid directly to A to Z Pediatric Therapy/ABA to Z, LLC.

RELEASE OF INFORMATION CONSENT:

_____I authorize A to Z Pediatric Therapy/ABA to Z, LLC to release information to health professionals, insurance companies, and/or Medicaid in order to process all medical claims on the patient's behalf through written or verbal communication, via regular mail, electronically, or by fax.

SMS TEXT MESSAGING TERMS OF SERVICE:

_____ I consent to receive SMS text messages from A to Z Pediatric Therapy/ABA to Z for appointment reminders, marketing messages, and general two-way communication, including potentially for administrative issues, such as billing, or for health-related issues, such as care reminders. I understand that text messaging may not be secure and will initiate a request in writing to A to Z Pediatric if I prefer another communication method.

_____ I agree to receive (I "opt in" to receiving) SMS text messages from A to Z Pediatric Therapy, related to services provided. Message and data rates may apply, and message frequency varies. I may text STOP at any time to opt out of receiving SMS text messages from us. I may text us HELP at any time to receive help. SMS text messages from A to Z Pediatric Therapy may originate from the organization's phone numbers, including: 678-733-9318 and/or 470-222-4381

_____ There may be terms in other agreements that also apply to A to Z Pediatric Therapy's use of SMS text messaging, such as general terms related to privacy and data handling for the organization that are not specific to SMS text messaging. I agree that I have reviewed all agreements that were provided to me. (See our privacy policy for more information.)

_____ _____

Patient Name Parent/Caregiver Name

_____

Phone Number

_____ _____

Parent/Caregiver Signature Date