GENERAL INFORMATION AND CONSENT

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

In consideration of the therapeutic services being rendered to Patient at Walker therapy Services, LLC, a Georgia limited liability company, herein referred to as the "Center," the Patient, or the undersigned representative acting on behalf of Patient (as used in this from, the "Patient" includes a representative signing or acting on behalf of Patient), agrees and consents as follows:

1. CONSENT AND TREATMENT AUTHORIZATION

Patient consents to the rendering of therapeutic treatment as considered being necessary and appropriate by the attending therapist or other practitioner. Patient authorizes the attending therapist to furnish and provide the treatment and services ordered or requested by the attending therapist or other practitioner acting in his or her place. **The consent to receive therapeutic treatment/services includes, but is not limited to, therapy involving: animals, exercise equipment, swimming pool, stairs, rock climbing wall, and other services which may be used in treatment of Patient.**

2. LEGAL RELATIONSHIP BETWEEN CENTER AND THERAPIST

Some of the professional therapists performing services at the Center are independent contractors and are not agents or employees of the Center. Independent contractors are responsible for their own actions and for identifying themselves to you as independent contractors, and The Center shall not be liable for the acts or omissions of any such independent contractors.

3. DISCLAIMER OF GUARANTEES

I acknowledge that the practice of a therapy discipline (Physical Therapy, Occupational Therapy, and Speech and Language Therapy) is not an exact science and that treatment may involve risk of adverse results and injury. I acknowledge that no guarantees have been made as to the results of therapeutic treatment (herein called "Treatments") that may be undertaken at the Center. While routinely performed without incident, there may be material risks associated with each of these Treatments. I understand that it is not possible to list every Treatment or every risk for every Treatment and that this form only attempts to identify the most common Treatments and possible material risks associated with Treatments. I also understand that various professional therapists may have differing opinions as to what constitute material risks associated with specific Treatments.

4. EXPLANATION OF TREATMENTS AND MATERIAL RISKS

By signing this form:

a) I consent to therapist performing Treatments as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those Treatments that may be unforeseen or not known to be needed at the time this consent is obtained; and

b) I acknowledge that I have been informed in general terms of the nature and purpose of Treatments and the material risks of Treatments. Treatments may include, without limitation, the following:

(A) ***Aquatic Therapy:*** Associated material risks include, but are not limited to: contagious exposure, infection, allergic reaction, skin rashes, lung epithelium, respiratory illness, ocular illness, drowning, trauma due to inappropriate use of pool.

(B) ***Hippotherapy and Equine Assisted Therapy:*** Associated material risks include, but are not limited to: allergic reaction, bruises, strains, sprains, fractures, dislocations, concussions, lacerations or trauma due to horse bite, lacerations or trauma due to horse kick, falling while riding, mounting or dismounting, or other inherent risks of equine activities.
WARNING: Under Georgia law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities. Pursuant to Chapter 12 of Title 4 of the Official Code of Georgia Annotated.

(C) ***Rock Wall Climbing:*** Associated material risks include, but are not limited to: cuts, abrasions, bruises, sprains, fractures, dislocations, contusions, trauma due to accidental injury.

(D) ***Use of Exercise Equipment:*** Associated material risks include, but are not limited to: cuts, abrasions, bruises, sprains, fractures, dislocations, contusions, trauma due to accidental injury.

(E) ***Stair Climbing:*** Associated material risks include, but are not limited to: cuts, abrasions, bruises, sprains, fractures, dislocations, contusions.

(F) ***Feeding and Swallowing Therapy:*** Associated material risks include, but are not limited to: allergic reaction, choking, vomiting, constipation, diarrhea.

(G) ***Use of Student and/or Volunteers:*** Walker Therapy utilizes volunteers and contracts with educational facilities to provide required fieldwork placements. I understand and consent to the fact that these individuals may assist the treating therapist with services provided.

If I have any questions or concerns regarding these Treatments, I will ask my attending therapist to provide me with additional information. I also understand that my attending therapists may ask me to sign additional informed consent documents concerning these or other Treatments.

5. PATIENT DISCLOSURE RESPONSIBILITIES

Patient accepts complete responsibility for disclosing all pertinent information to the Center regarding Patient's current medical condition and medical insurance coverage. Patient understands that the healthcare professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family, guardians, caregivers or others having knowledge about me, in determining whether to perform or recommend the Treatments. Patient therefore agrees to provide accurate and complete information about my medical history and conditions.

Below is for Office Use Only:

Patient Name:	Id Number:

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6. ASSIGNMENT OF INSURANCE BENEFITS

The Patient agrees to pay to Center all insurance benefits paid directly to the insured for services rendered to Patient by Center.

7. ASSIGNMENT OF MEDICARE BENEFITS

Patient certifies that the information given in applying for payment under Title XVII of the Social Security Act is correct. Patient authorizes any holder of medical or other information to release to the Center or its intermediaries or carriers any and all information needed to process Medicare claims. Patient requests that payment of authorized benefits be made on Patient's behalf to the Center. Patient assigns the benefits payable for Treatments rendered by the Center and therapists rendering care and/or Treatment to Patient and authorizes the Center and therapists to submit claims to Medicare for payment.

8. ASSIGNMENT OF INSURANCE BENEFITS

For the care and Treatments received, Patient irrevocably assigns to the Center all insurance benefits and settlements whether medical or liability insurance including, but not limited to, the proceeds of any settlement or judgment of any third party claim up to the amount necessary to pay for any and all services rendered. Patient authorizes such benefits, judgments and settlements to be paid directly to the Center.

9. ASSIGNMENT OF MEDICAID BENEFITS

Patient certifies that the information given in applying for payment under Title XIX of the Social Security Act is correct. Patient authorizes any holder of medical or other information to release to the Center or its intermediaries or carriers any and all information needed to process Medicaid claims. Patient requests that payment of authorized benefits be made on Patient's behalf to the Center. Patient assigns the benefits payable for Treatments rendered by the Center and therapists rendering care and/or Treatment to Patient and authorizes the Center and therapists to submit claims to Medicaid for payment.

11. AUTHORIZED REPRESENTATIVE

By signing this form, I am giving consent for Walker Therapy Services to act on my behalf as an authorized representative. An authorized representative is a person with written consent to decide health issues for the member. Consent is given for an agent of Walker Therapy Services to submit an appeal on my behalf, if it becomes necessary to file an appeal to receive physical, occupational or speech therapy services with my insurance company. This includes Amerigroup Community Care, and Peach State Health Plan in addition to any other healthcare reimbursement source. This consent can be withdrawn at any time with written notice. This does not give consent to make decisions on my behalf that would cause me to be financially responsible.

12. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization is granted to the Center by Patient to release to Patient's insurance company or companies, their agents, or other third party payors, confidential or other information (including but not limited to, copies of Treatment records, Individual Education Plans, and Individual Family Service Plans) as may be requested or required for the completion of claim process related to Patient's bills for Treatments.

13. APPOINTMENT CANCELLATION AND NO SHOW FEES

Patient understands and agrees that Center will impose a $25 (twenty-five dollar) fee for cancellation of a scheduled appointment within 24 hours of the appointment time or if the Patient does not show up for the scheduled appointment. This charge cannot be covered by insurance and will be billed separately from any other billing for therapy. Patient understands and agrees to pay this charge within one month of the missed visit.

14. TEACHING ACTIVITIES

Patient recognizes that among those who may attend Patient at the Center are therapists and healthcare personnel who may be in training and who, unless specifically requested otherwise, may be present and participate in Patient care activities as part of the education. Consent is hereby given for the presence and participation of such persons, and the sharing of confidential health information of Patient with such persons, as deemed appropriate by the attending therapist.

15. PATIENT SURVEY

Patient authorizes the Center or its authorized representative to contact him or her after completion of Treatments for the purpose of conducting satisfaction surveys and other studies.

16. RELEASE FROM RESPONSIBIILTY FOR VALUABLES, VEHICLES AND PERSONAL BELONGINGS

Patient understands that the Center does not provide facilities for the security and safekeeping of personal belongings, including but not limited to, any valuables brought to or vehicles driven onto the Center's property. Patient hereby releases the Center from any responsibility due to loss or damage of any personal belongings that Patient or any persons accompanying Patient to the Center may bring to the Center.

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17. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) DISCLOSURE

Patient acknowledges that Walker Therapy Services, LLC, has furnished Patient a copy of a notice of Patient's rights under the Health Insurance Portability and Accountability Act and that Patient had read and understands these rights.

18. PATIENT'S OR REPRESENTATIVE'S CERTIFICATION

Patient, or the undersigned representative authorized to act on Patient's behalf, certifies that this form has been read and understood, and that satisfactory answers or explanations have been given for any questions asked by Patient or Patient's representative. If this form is signed by the Patient's representative, the representative certifies that he/she has the legal right to consent to Treatments and to otherwise act for the Patient, and agrees to indemnify and otherwise hold harmless the Center from any liability to Patient arising from any unauthorized signing of this form by representative on Patient's behalf.

19. PRIVACY RIGHTS AND PRACTICES

I acknowledge by signing below that I have received my Notice of Privacy Practices and Notice of Individual Rights. I, the undersigned, declare that the information I have provided is true to the best of my knowledge. I understand that if I have provided any false identification or other knowingly false information having done so may result in criminal prosecution.

20. VALIDITY OF FORM

Patient authorizes that a copy of this document, electronic or otherwise, may be used in place of the original and is as valid as the original.

_____ _____

Signature: Patient or Agent/Guardian/Representative Date

_____

Printed name of Patient's Agent/Guardian/Representative

_____ _____

Agent/Guardian/Representative Relationship to Patient Witness

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Patient Name:	Id Number: