IN-SYNC & SOCIAL

Patient Consent and Authorization Form

Patient Name:	
Consent to Treatment and Authorization for Release of Information	
I hereby authorize In-Sync & Social(ISS)staff to evaluate and treat the above named patient as prescribed by my physician and recommended by the therapist. I understand that I have the right to remain present during all therapy sessions, and ask any questions I may have of the therapy program. I authorize ISS to request appropriate information from my child's physicians. I further authorize ISS to release any pertinent information to these physicians. I have read and understand the above consent.	
Parent/Guardian Signature:	Date:

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)	
I hereby acknowledge that I can print off a copy of ISS Privacy Practices from the website. In addition, I hereby consent to the use and disclosure of mine and my child's personal health information for the purposes of treatment, payment, and health care operations.	
Parent/Guardian Signature:	Date:

Assignment of Benefits	
I hereby authorize payment directly to In-Sync and Social and its employees for therapy servic provided to my child. This is a direct assignment of my rights and benefits under my insurance policy. A photocopy of this assignment shall be considered as effective and valid as the original.	
Parent/Guardian Signature:	Date: