Client: _____ DOB: _____

Dear Parent/Guardian:

Pediatric Boulevard would like to thank you for considering the telehealth platform as an option to continue your child's continuity of care. As you know, we are committed to seeing your child obtain his/her goals by their anticipated start date. We appreciate all of you for keeping your child's goals as a priority.

Based on the responses to the inquiry about telehealth, Pediatric Boulevard has decided to trial the telehealth platform with a few clients. Please note that although we feel telehealth is valuable, we realize that our families our adjusting to a "new normal." Our goal is to assist your family along the journey while providing valuable skills that may help along the process. It may comfort you to know that this is Pediatric Boulevard's first experience with telehealth. With your help, we will make the telehealth experience a very positive one for your child. We are all in this together.

By signing below you acknowledge and understand that Pediatric Boulevard is not using a HIPPA secured platform to provide therapy sessions via telehealth. You agree that all financial obligations will remain the same based on what you signed and have on file for your regular outpatient therapy appointments at Pediatric Boulevard. You also agree to pay the remaining balance if a balance due.

Thank you for being such a valued client at the Pediatric Boulevard family. We look forward to receiving your feedback regarding the telehealth platform.

Best in Health,
Pediatric Boulevard

I hereby authorize Pediatric Boulevard, PLLC to furnish my insurance carrier/health plan any information it requests. I also authorize my insurance company/health plan to reimburse Pediatric Boulevard, PLLC directly for all covered services rendered.

I understand that my health policy may not pay for these services. By signing below, I acknowledge and understand that I am therefore solely responsible for the total amount of all costs for the services rendered by Pediatric Boulevard related to the procedure(s) and/or treatment(s) identified at the time of service. I agree to be personally and fully responsible for timely payment of the amount billed.

Signature of Patient/Legal Guardian: _____ Date: _____ Time: _____

Printed Name of Patient/Legal Guardian: _____

Relationship to Patient: _____

*** CLICK HERE to submit this form through our secured portal. ***