P.O. Box 822
York, ME 03909
P 207-203-9001
F 207-274-7012
molly@memory-partners.com

Consent for Occupational Therapy

- I consent for occupational therapy evaluations, screenings and treatment by Memory Partners LLC.
- I understand that I am expected to be an active partner in open, ongoing communication with the Memory Partner OT to ensure that I understand the services.
- I understand that I am expected to ask questions I may have about the evaluation and treatment and have the right to decline any activity at any time.
- I understand that occupational therapy evaluation and treatment does include movement and physical activity and the possible risk of accidental injury.
- I hereby, intending to be legally bound, waive forever, for myself, my family and my heirs any and all claims for damages against Memory Partners LLC, the owner(s) or independent contractor for any and all injuries I may sustain as a result of an accidental injury while participating in any and all activities with Memory Partners LLC.
- Grievance or Complaint Policy
  - Any complaint or grievance regarding services provided or billing issues can be communicated to Memory Partners LLC through written or verbal communication.
  - A form will be provided as needed.
  - Signing this form indicates acknowledgement of this policy.

Benefit Assignment/Release of Information

- I authorize any and all insurance companies that I utilize to make payments directly to Molly Harrigan at Memory Partners LLC.
- I authorize the release of any and all medical information by telephone, fax, letter or secure email which may be needed to process claims and facilitate reimbursement to Molly Harrigan OT at Memory Partners LLC.

Financial Policy Statement

- We will bill your insurance carrier as a courtesy to you
- If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same payment to Molly Harrigan at Memory Partners LLC
- You agree to pay any co-pay, deductible or balance after insurance has been billed and processed to Molly Harrigan at Memory Partners LLC unless otherwise specified
- You agree to pay for any OT services provided that is not covered by insurance.

I understand, acknowledge and agree to all above consents and policies.

Signature of patient or DPOA/Guardian : ____

Date: ____