



**CONSENT FOR SERVICES,  
ASSIGNMENT OF BENEFITS,  
RELEASE OF INFORMATION, AND  
PERMISSION TO BILL MEDICAID**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

Name of Parent: \_\_\_\_\_ Parent's Medicaid Number \_\_\_\_\_

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**Consent**

I hereby consent to the services provided by the staff of Confluence Academy ("Confluence") for my child who is a student at Confluence Academy. These services may include physical therapy, speech therapy, occupational therapy, counseling, and/or social work.

**Assignment of Benefits**

I hereby authorize direct payment to Confluence of all Medicaid benefits applicable to the services provided by Confluence and its staff, which are now or which shall become due and payable.

**Medicaid Insurance Benefits**

I certify that the information given by me is correct. I authorize the release of medical or other information to the Centers for Medicare or Medicaid Services or its intermediaries or carriers, or MO HealthNet concerning this or a related Medicaid claim filed by Confluence. I request that payment of authorized benefits be made on my child's behalf. I certify that I have read and understand, and accept the above and further certify that I am the parent or duly authorized representative of the student in signing this agreement on my child's behalf.

**Release of Information<sup>1</sup>**

I acknowledge that there are instances when Confluence must release information concerning the services that my child received, including copies of records to certain individuals or entities who are involved in the services, payment for such services, and other activities related to such services. Such disclosures include:

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<sup>1</sup> If you would prefer to apply for benefits directly, you may do so by calling MO HealthNet at 1-888-275-5908 or by going to <http://www.dss.mo.gov/mhd/>.

- a. Any professionals involved in the services provided to my child for the purpose of facilitating the continuity of services.
- b. Any person or entity responsible for or any person or entity acting as an agent for the party responsible for payment, including third party payers, governmental agencies, payment for services rendered to my child by Confluence by Confluence employees.
- c. Any federal, state or other governmental or quasi-governmental agencies or other such parties as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
- d. Any person or entity participating in quality studies, utilization review or similar studies of the services provided by Confluence.

I acknowledge that I have read this form and understand its contents fully.

A copy of this form shall have the same force and effect as the original. The consent granted herein shall remain in effect until revoked in writing by me.

\_\_\_\_\_  
Signature of Parent, Legal or Authorized  
Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date