500 E. Woodrow Wilson Ave
Building C
Jackson, Mississippi 39216
(601) 910-7300

Patient Demographic Information

Name: _____

Address:_____ City/State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Age:_____ Date of Birth:_____ Sex:_____ Marital Status:_____

Social Security Number: _____ Driver's License Number: _____

Referring Physician:_____ Phone:_____

If patient is a minor, name of parent/guardian:_____

Employment Information

Employer:_____ Occupation:_____

Employer's Address: _____

Employer's Phone:_____ Email Address:_____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Occupation: _____

Spouse's Employer Address: _____

Spouse's Employer Phone: _____ Email Address: _____

Emergency Contact

Name:_____ Relationship:_____ Phone:_____

Insurance Information

Insurance Company:_____

Insurance Company's Address: _____ Phone: _____

Name of Insured:_____Insured's Date of Birth:_____

Insured's Address (only if different than patient): _____

Policy Number: _____ Group Number: _____

Before signing this document, verify that the content you are signing is correct.

Patient Signature _____ Date _____

HEALING HANDS
REHABILITATION SERVICES

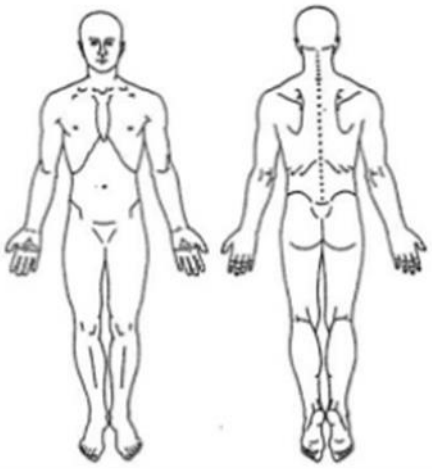
Medical History Form

Patient Name: _____ Date: _____

1) What areas of the body or conditions are you currently seeking physical therapy treatment for?
   _____
   _____

2) If there are multiple areas of involvement, which region/problem is of greatest concern at this time?
   _____
   _____

3) Have you been treated for this same problem before? _____
   a. If yes, when and who treated this problem?
      _____



Shade your areas of pain and discomfort on the figures to the left:

Please rate your pain on the scale below from 0 to 10:
(0=no pain 10= worst pain)

Pain at rest: 0 1 2 3 4 5 6 7 8 9 10

Pain with activity: 0 1 2 3 4 5 6 7 8 9 10

What is the frequency of your pain? Constant Intermittent

Is your pain worse in the: AM PM Mid-Day

4) Current Level of Physical Activity: High Medium Low None

5) Please list all prescription medications you are taking, reason for medication, frequency, and route of administration. Attach list if needed.
   _____
   _____
   _____
   _____

6) Medical History (Please circle any that apply past or present):

Cardiovascular Disease	Asthma/Shortness of Breath	Hepatitis/Liver Disease	Depression
High Blood Pressure	Congestive Heart Failure	Epilepsy/Seizures	Anemia
Diabetes (Type 1 or 2)	Multiple Sclerosis	Thyroid Condition	Osteoporosis
Stroke or Heart Attack	Fibromyalgia	Neurological Condition	Chronic Infections
Arthritis (Osteo/Rheumatoid)	Migraines/Headaches	Eating Disorder	Lupus
Kidney/Renal Disease	Dizziness/Vertigo	Drug/Alcohol Abuse	HIV/AIDS

Cancer (Type _____ Location _____ Year _____ Status _____)

Other _____

7) Do you have a pacemaker, internal defibrillator, insulin pump, metal factor or any other implanted medical devices?

_____

8) Are you currently pregnant or is there a possibility that you may be pregnant? _____
   a. If yes, how many weeks pregnant are you? _____

I certify, to the best of my knowledge that the above information is complete and true. If my medical health status changes, I will inform a member Healing Hands Rehab Staff immediately.

Patient Name (Please Print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent Consent to Treat a Minor (for patients under the age of 18)

Being the parent or legal guardian of _____(minor's printed name), I _____ (parent/guardian printed name) hereby authorize Healing Hands Rehabilitation Services, LLC to perform physical therapy evaluation and/or treatment of the above mentioned minor.

Minor's Date of Birth: _____

Parent/Legal Guardian Signature _____ Date _____

HEALING HANDS
REHABILITATION SERVICES

TERMS OF ACCEPTANCE AND CONSENT TO TREATMENT

Informed Consent

A patient willfully choosing to be treated by Healing Hands Rehabilitation Services, LLC gives Healing Hands Rehabilitation Services, LLC permission and authority to care for him/her in accordance with physical, occupational and/or speech therapy tests, procedures and treatments. Physical, occupational and/or speech therapy is usually beneficial and seldom causes any problems, and in rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. Therefore in no way will the treating clinician provide services of any kind if he/she is aware that such care may be contraindicated.

It is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever it is he/she is suffering from; latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the treating practitioner. The treating practitioner provides a specialized, non-duplicating health care service, and furthermore, any risk involved regarding physical, occupational and/or speech therapy will be explained to you upon your request. Your treating practitioner is licensed in a special practice and is available to work with other types of physicians, practitioners and providers in your health care regimen.

Acknowledgement and Consent to Treat

I have read and understand the terms outlined above and consent to all necessary treatment as determined by Healing Hands Rehabilitation Services, LLC.

I have reviewed the notice of privacy rights (HIPAA) and have been provided an opportunity to discuss my right to privacy. I will be given a copy of the privacy rights upon request.

Print Name: _____ Signature: _____ Date: _____

Consent to Evaluate and Treat a Minor

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant authorization for my child to receive Physical, Occupational and/or Speech Therapy services.

Signature: _____ Date: _____

PATIENT FINANCIAL AGREEMENT

Thank you for choosing Healing Hands Rehabilitation Services as your therapy provider. We are committed to providing you with quality and affordable therapy services. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. **Insurance:** We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

2. **Patient Payment:** All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. **Registration:** All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment, and you will be responsible for the balance that remains.

4. **Claims:** We will submit your claims and assist you in any way that we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

5. **Uninsured Patients:** We offer a self-pay discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed, and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action.

6. **Credit and Collection:** If your account is more than 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If an account is sent to collection, it is the policy of this office to discharge the patient and possibly immediate family members from the practice. You will at that time be notified by regular and certified mail that you will have 30 days to find alternative medical care. During that 30-day period our therapists will be able to treat you only on an emergency basis.

7. **Missed Appointments:** Our policy is to charge $50 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read and understand the financial policy and agree to abide by its guidelines.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

X _____ Date _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

HEALING HANDS
REHABILITATION SERVICES

500 E. Woodrow Wilson Ave.
Building C
Jackson, Mississippi 39216
601-910-7300
www.hhrehab.com

NOTICE OF PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Healing Hands Rehabilitation Services, LLC is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

PAYMENT

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

WORKERS' COMPENSATION

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

EMERGENCIES

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition in the event of an emergency or of your death.

PUBLIC HEALTH

As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS

We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS

We may disclose your health information to coroners or medical examiners.

ORGAN DONATION

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

RESEARCH

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

SPECIALIZED GOVERNMENT AGENCIES

We may disclose your health information for military, national security, prisoner and government benefits purposes.

MARKETING

We may contact you for marketing purposes or fund raising purposes.

CHANGE OF OWNERSHIP

In the event that Healing Hands Rehabilitation Services, LLC is sold or merged with another organization, your health information/record will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Healing Hands Rehabilitation Services, LLC.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Healing Hands Rehabilitation Services, LLC amend your protected health information. Please be advised, however, that Healing Hands Rehabilitation Services, LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Healing Hands Rehabilitation Services, LLC.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY RIGHTS

Healing Hands Rehabilitation Services, LLC reserves the right to amend this Notice of Privacy Rights at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Healing Hands Rehabilitation Services, LLC is required by law to comply with this Notice.

Healing Hands Rehabilitation Services, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Healing Hands Rehabilitation Services, LLC by calling this office (601) 910-7300. If Healing Hands Rehabilitation Services, LLC is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

COMPLAINTS

Complaints about your Privacy rights, or how Healing Hands Rehabilitation Services, LLC has handled your health information should be directed to Healing Hands Rehabilitation Services, LLC by calling (601) 910-7300 if Healing Hands Rehabilitation Services, LLC is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complain, you may submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Avenue, S.W.

Room 509F HHH Building

Washington, DC 20201

This notice is effective as of today's date listed below.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Healing Hands Rehabilitation Services, LLC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____

Patient Signature Date

HEALING HANDS
REHABILITATION SERVICES

PHOTO/VIDEO CONSENT AND RELEASE FORM

Without expectation of compensation or other renumeration, now or in the future, I hereby give my consent to Healing Hands Rehabilitation Services, LLC, its affiliates and agents, to use my image and likeness and/or any interview statements from me in its publications, advertising or other media activities (including the Internet).

This consent includes, but is not limited to (Initial where applicable):

_____ Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/or record my voice;

_____ Permission to use my name; and

_____ Permission to use quotes from the interview(s) (or excerpts of such quotes); the film, photograph(s), tape(s) or reproduction(s) of me and/or my voice in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness.

This consent is given in perpetuity and does not require prior approval by me.

Name _____

Signature _____

Address _____

_____

Date _____

The below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of such minor child.

Signature of Parent/Legal Guardian _____

Print Name _____

The following is required if the consent form has to be read to the parent/legal guardian: I certify that I have read this consent form in full to the parent/legal guardian whose signature appears above.

Date _____

Signature of Organizational Representative _____

I _____ (patient or representative) authorize Healing Hands Rehabilitation Services to deliver or cause to be delivered the following types of messages (for example) by voice messaging or text messaging:

Appointment reminders

Visit recalls

Billing reminders

I authorize such messages to be delivered to the following phone number(s):

_____

_____

_____

I understand that by signing the agreement, I am authorizing Healing Hands Rehabilitation Services to deliver or cause to be delivered to me certain text messages and/or voice messages and that I am not required to sign this agreement in order to receive services from Healing Hands Rehabilitation Services.

Signature (patient or guarantor)_____

Patient's Printed Name _____ Date _____

Guarantor's Printed Name _____ Date _____

Opt-In Messaging Authorization

HEALING HANDS
REHABILITATION SERVICES

105 Lexington Drive
Suite H
Madison, Mississippi 39110
(601) 910-7300

Date: _____

Patient Name: _____

Patient Date of Birth: _____

Due to HIPAA Regulations, I hereby authorize the following names of those listed below to discuss and participate in my medical care (names of family members/friends who may be calling on your behalf; it is not necessary to list doctors' names). I understand that if the names are not listed below, Healing Hands Rehabilitation Services, can not release any information.

NAMES	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature _____ Date _____

Parent/Guardian Signature (if patient is a minor)

_____ Date _____

105 Lexington Drive
Suite H
Madison, Mississippi 39110
(601) 910-7300

REQUEST FOR RELEASE OF MEDICAL RECORDS

Name: _____ Date of Birth: ___/___/___

Purpose of Release: _____

A minimum of (7) days are required to release medical records.

If a third party is involved, the following must be completed:

I grant permission for my medical records to be released to:

_____

_____

_____

_____

Description of information released:

Complete records □

Therapist reports □

Approximate dates of treatment: From_____ to _____

The following charges apply for physical copies: $1.00 per page for the first 10 pages; $.50 for each page up to 50 pages; $.25 for each subsequent page. No charges for faxed copies.

_____ _____

Patient/Parent Signature Date

COMPLETE UPON RECEIPT

Your fee for a complete copy of medical records from Healing Hands Rehabilitation Services is: $_____.

I _____ certify that I have received the requested records from Healing Hands Rehabilitation Services, LLC.

Complete Records ☐ Therapist Reports ☐

Patient: _____ Date: _____

Witness: _____ Date: _____

HEALING HANDS
REHABILITATION SERVICES

NO CALL/NO SHOW AND CANCELLATION POLICY

We appreciate having you as a patient and are committed to helping you achieve optimal results. At Healing Hands Rehabilitation Services, we strive to provide quick and timely services to all of our patients. In order to maintain this level of service, **effective September 15, 2024**, all therapy appointments must be cancelled and/or rescheduled 48 hours prior to scheduled appointment(s). This will enable us to fill your cancelled appointment spot with patients who may be waiting for an appointment.

Your adherence to the recommended number of treatments is a vital component of your progress in physical, occupational and/or speech therapy. With the exception of emergencies, it is expected that you keep all of your scheduled appointments. If you are unable to keep a scheduled appointment, please call our office to reschedule. If you need to call after hours, please leave a message on the answering machine. Please note that Healing Hands Rehabilitation Services will charge a **$50** no-show fee for **each** missed PT, OT and/or ST appointment. Patients' will have to call to reschedule further appointments and all fees **must be paid in full** prior to being seen.

In instances of repeated non-compliance with missing 3 or more scheduled appointments, we reserve the right to discontinue care. We will inform your prescribing physician and insurance company that your physical, occupational and/or speech therapy service(s) have been discontinued due to non-compliance with the prescribed rehabilitation order. If therapy needs to be resumed, we will require a new referral from your physician.

Thank you for your cooperation!!

Patient Name: _____

Patient Signature: _____

Parent/Guardian Signature (if patient is a minor): _____

Date: _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other _____

Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVC: _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize **Healing Hands Rehabilitation Services,** to charge my credit card above for agreed upon charges. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date