HEALING HANDS
REHABILITATION SERVICES

105 Lexington Drive, Suite H, Madison, MS 39110
Phone (601) 910-7300 Fax (601) 910-7071

CASE HISTORY FORM

Healing Hands Rehabilitation Services requests this information for the sole purpose of completing your child's evaluation. Completion of this form is a part of the evaluation process and assists us in determining our recommendations for your child.

GENERAL INFORMATION

Child's Name: _____ Date of Birth: _____ Age: _____
Person Providing Information: Today's Date: _____ Sex: _____
_____ Physician: _____
Relation to Child: _____ Physician's Address: _____
Child's Address: _____ _____
Mother's Name: _____ Physician's Phone: _____
Home Telephone Number: _____ Father's Name: _____
Mother's Date of Birth: _____ Father's Date of Birth: _____
Mother's Cell Phone Number: _____ Father's Cell Phone Number: _____
Mother's Work Phone Number: _____ Father's Work Phone Number: _____
Mother's Email Address: _____ Father's Email Address: _____
Child's Social Security #: _____ Referred By: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

RESPONSIBLE PARTY

Patient's Relationship to Responsible Party: ❑ Self ❑ Child ❑ Spouse ❑ Guardian ❑ Other: _____
Name of Responsible Party: _____ Gender: ❑ Male ❑ Female
Mailing Address: _____
Same as above ❑
Billing Address: _____
SSN: _____ DOB: _____

INSURANCE INFORMATION

Insurance Name: _____ Policy #: _____
Group Name/#: _____ SSN: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's Address: _____ Subscriber's Gender: _____
_____ Subscriber's Phone #: _____
Employer: _____ Employer's Phone #: _____
Employer's Address: _____ Relationship to patient: _____
_____ Effective Date: _____

Please describe all areas of concern:

( ) Fine Motor (use of hands, dressing, handwriting, stacking blocks) _____

( ) Gross Motor (crawling, walking, jumping, running, climbing) _____

( ) Speech/Language _____

( ) Sensory _____

( ) Feeding _____

( ) Behavior _____

Other concerns: _____

_____

_____

Has your child received any previous therapy or evaluations regarding his/her development? If so, please indicate dates of service and name(s) of the provider(s)? _____

_____

List any significant medical events that have occurred over the past 12 months (i.e., surgery, major illnesses, injuries, etc.…) _____

_____

_____

FAMILY HISTORY

Father's Name: _____ Age: _____ Occupation: _____

Mother's Name: _____ Age: _____ Occupation: _____

Is child adopted? _____ If so, at what age? _____ From what Country? _____

Marital status of parents (**circle one**): Married Living Together Separated Divorced Other

Who lives in the house with this child? (If children are listed, please give names and ages)

_____

_____

Please indicate if there have been any instances of the following in your immediate or extended family members:

( ) ADHD ( ) Learning Disabilities ( ) Communication Disorders ( ) Autism/PDD ( ) Hearing Loss

( ) Stuttering

PREGNANCY AND BIRTH HISTORY

1. Were there any complications during this pregnancy? Y N
   Please describe:
2. Was this pregnancy full-term? If not, please give gestational age at time of delivery? Y N
3. Were any drugs or medications taken during this pregnancy? If so, please specify: Y N
4. Were there complications during labor/delivery? Please explain: Y N
5. Please list birth weight and length. Weight: Length:
6. Was the delivery vaginal, breech or caesarian? (Please circle response)
7. Were forceps/suction used? Y N
8. Were there any complications following delivery? Y N
9. How long was he/she in hospital after birth?
10. Were there difficulties with feeding? Y N
11. Did your child bottle-feed or breast feed? (Please circle response)
12. Did your child have difficulties sucking? Y N

13. Are there any issues with sleep patterns? If so, please explain. Y N

MEDICAL HISTORY

14. Has your child had any of the following illnesses?
    a. Meningitis Y N
    b. Chicken Pox Y N
    c. Seizures Y N
    d. Frequent Ear Infections Y N
    e. Does your child have PE tubes? Y N
    f. Excessive vomiting or reflux. Does/did you child exhibit irritability/fussiness following feedings? If yes, please describe: _____ Y N
    _____
    g. Are there any current or previous feeding or swallowing difficulties? If yes, please describe: _____ Y N
    h. Cleft Palate Y N
    i. Does your child have vision problems? If yes, please describe: _____ Y N
    j. Does your child use any adaptive equipment? Describe _____ Y N

GROWTH AND DEVELOPMENT

Answer question 15 if your child is 5 years or younger. For children older than 5 years, begin with question 16.

15. What age did your child:	Age	Comments
a. Roll over from stomach to back?		
b. Roll from back to stomach?		
c. Sit independently?		
d. Crawl?		
e. Cruise around furniture?		
f. Walk independently?		
g. Speak first word?		
h. Speak 2-word sentences?		
i. Drink from a cup?		
j. Use a spoon?		
k. Dress independently?		
l. Toilet trained?		
m. Toilet trained through the night?		

16. Estimate how many words are in your child's expressive (speaking) vocabulary.
    <25 _____ 25-75 _____ >75 _____
17. Estimate how many words are in your child's receptive (words they understand) vocabulary.
    <25 _____ 25-75 _____ >75 _____
18. Describe your child by answering yes or no to the following:
    a. is mostly quiet Y N
    b. is overly active Y N
    c. tires easily Y N
    d. talks constantly Y N
    e. impulsive Y N
    f. restless Y N
    g. stubborn Y N

h. resistant to changes Y N
i. overreacts Y N
j. fights frequently Y N
k. is usually happy Y N
l. has frequent temper tantrums Y N
m. is clumsy Y N
n. has difficulty separating from caregiver Y N
o. has nervous habits or tics Y N
p. has poor attention span Y N
q. is frustrated easily Y N
r. has unusual fears, please describe Y N
s. rocks self frequently Y N
t. exhibits difficulty learning new tasks Y N
u. avoids touch Y N
v. craves touch, seeks it out Y N
w. shy Y N
x. compliant Y N

SOCIAL/EMOTIONAL DEVELOPMENT

19. Is your child easily managed at home? Y N
20. Who manages him/her best? Y N
21. Does your child empathize with others' feelings (happy, sad, angry)? Y N
22. Does your child understand punishment, and does he/she show remorse? Y N
23. Does your child understand praise and reward? Y N
24. Does your child recognize danger (climbing on ladders)? Y N
25. Does your child show concern when separated from parents? Y N
26. Is your child affectionate toward familiar adults? Y N
27. Does your child have friends? Y N

COMMUNICATION HISTORY

28. How does your child communicate at home, at school, etc.? (i.e., sign, verbal, augmentative/alternative communication device)
29. Can your child:
    a. Understand and follow simple directions? Y N
    b. Identify body parts? Y N
    c. Recognize pictures of common objects? Y N
    d. Turn his/her head when name is called? Y N
    e. Communicate with intent? Y N
    f. Answer "wh" questions? Y N
30. Does your child have hearing loss? Y N
31. Has your child had his/her hearing tested? If so, when, and what were the results? Y N

32. Is a language other than English spoken at home? If so, which one? Y N

33. Please describe any communication difficulties.

34. When was the problem first noticed?

EDUCATIONAL BACKGROUND

35. Does your child attend school? Where?

36. What grade is he/she in now?

37. Does your child receive special education or therapies in school (PT, OT, Speech)? If so, please give details (Frequency, Length of Sessions, Individual/Group).

38. Please list below where your child has received therapy or treatment related to his/her present problems.

39. Is there anything else that you want us to know about your child?

We recognize that managing your family's schedules can be complicated, and we make every effort to accommodate each family's scheduling needs; however, the welfare and safety of your child is our foremost concern. Therefore, we must insist that if you plan to leave the office during evaluation or treatment, we must have a cell phone or other number for immediate contact with you and you must be back on time to pick up your child. Consultation with your child's therapist at the end of each session is an integral part of the therapy process. In addition, we have no one available to be responsible for your child after evaluation/therapy sessions end. If both criteria cannot be met it will be necessary for you to remain in the waiting are during the evaluation/therapy session.

I have read the above statement and understand that it is essential that I can be reached immediately if I must leave the waiting area during my child's therapy. I also understand the importance of being available at the end of the therapy session for consultation with my child's therapist(s).

_____

Parent/Guardian Signature

Short Sensory Profile

SENSORY PROFILE

Winnie Dunn, Ph.D., OTR, FAOTA

Child's Name: _____ Birth Date: _____ Date: _____

Completed by: _____ Relationship to Child: _____

Service Provider's Name: _____ Discipline: _____

INSTRUCTIONS

Please check the box that best describes the frequency with which your child does the following behaviors. Please answer all of the statements. If you are unable to comment because you have not observed the behavior or believe that it does not apply to your child, please draw an X through the number for that item. Please do not write in the Section Raw Score Total row.

Use the following key to mark your responses:

ALWAYS	When presented with the opportunity, your child always responds in this manner, 100% of the time.
FREQUENTLY	When presented with the opportunity, your child frequently responds in this manner, about 75% of the time.
OCCASIONALLY	When presented with the opportunity, your child occasionally responds in this manner, about 50% of the time.
SELDOM	When presented with the opportunity, your child seldom responds in this manner, about 25% of the time.
NEVER	When presented with the opportunity, your child never responds in this manner, 0% of the time.

Item	Tactile Sensitivity	ALWAYS	FREQUENTLY	OCCASIONALLY	SELDOM	NEVER
1	Expresses distress during grooming (for example, fights or cries during haircutting, face washing, fingernail cutting)					
2	Prefers long-sleeved clothing when it is warm or short sleeves when it is cold					
3	Avoids going barefoot, especially in sand or grass					
4	Reacts emotionally or aggressively to touch					
5	Withdraws from splashing water					
6	Has difficulty standing in line or close to other people					
7	Rubs or scratches out a spot that has been touched					
	Section Raw Score Total					
Item	Taste/Smell Sensitivity					
8	Avoids certain tastes or food smells that are typically part of children's diets					
9	Will only eat certain tastes (list: _____)					
10	Limits self to particular food textures/temperatures (list: _____)					
11	Picky eater, especially regarding food textures					
	Section Raw Score Total					
Item	Movement Sensitivity					
12	Becomes anxious or distressed when feet leave the ground					
13	Fears falling or heights					
14	Dislikes activities where head is upside down (for example, somersaults, roughhousing)					
	Section Raw Score Total					
Item	Underresponsive/Seeks Sensation					
15	Enjoys strange noises/seeks to make noise for noise's sake					
16	Seeks all kinds of movement and this interferes with daily routines (for example, can't sit still, fidgets)					
17	Becomes overly excitable during movement activity					
18	Touches people and objects					
19	Doesn't seem to notice when face or hands are messy					
20	Jumps from one activity to another so that it interferes with play					
21	Leaves clothing twisted on body					
	Section Raw Score Total					

Item	Auditory Filtering	Always	Frequently	Occasionally	Seldom	Never
22	Is distracted or has trouble functioning if there is a lot of noise around					
23	Appears to not hear what you say (for example, does not "tune-in" to what you say, appears to ignore you)					
24	Can't work with background noise (for example, fan, refrigerator)					
25	Has trouble completing tasks when the radio is on					
26	Doesn't respond when name is called but you know the child's hearing is OK					
27	Has difficulty paying attention					
	Section Raw Score Total					
Item	Low Energy/Weak					
28	Seems to have weak muscles					
29	Tires easily, especially when standing or holding particular body position					
30	Has a weak grasp					
31	Can't lift heavy objects (for example, weak in comparison to same age children)					
32	Props to support self (even during activity)					
33	Poor endurance/tires easily					
	Section Raw Score Total					
Item	Visual/Auditory Sensitivity					
34	Responds negatively to unexpected or loud noises (for example, cries or hides at noise from vacuum cleaner, dog barking, hair dryer)					
35	Holds hands over ears to protect ears from sound					
36	Is bothered by bright lights after others have adapted to the light					
37	Watches everyone when they move around the room					
38	Covers eyes or squints to protect eyes from light					
	Section Raw Score Total					

FOR OFFICE USE ONLY

Summary

Instructions: Transfer the score for each section to the Section Raw Score Total column. Plot these totals by marking an X in the appropriate classification column (Typical Performance, Probable Difference, Definite Difference).*

SCORE KEY

1 = Always	4 = Seldom
2 = Frequently	5 = Never
3 = Occasionally	

Section	Section Raw Score Total	Typical Performance	Probable Difference	Definite Difference
Tactile Sensitivity	/35	35 ------- 30	29 ------- 27	26 ------- 7
Taste/Smell Sensitivity	/20	20 ------- 15	14 ------- 12	11 ------- 4
Movement Sensitivity	/15	15 ------- 13	12 ------- 11	10 ------- 3
Underresponsive/Seeks Sensation	/35	35 ------- 27	26 ------- 24	23 ------- 7
Auditory Filtering	/30	30 ------- 23	22 ------- 20	19 ------- 6
Low Energy/Weak	/30	30 ------- 26	25 ------- 24	23 ------- 6
Visual/Auditory Sensitivity	/25	25 ------- 19	18 ------- 16	15 ------- 5
Total	**/190**	190 -------155	154 -------142	141 -------38

*Classifications are based on the performance of children without disabilities ($n = 1{,}037$).

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THE PSYCHOLOGICAL CORPORATION®

A Harcourt Assessment Company

0761638040

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/ speech therapy tests, procedures and treatments. Physical/Occupational/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/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/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 each missed appointment not canceled within 48 hours of scheduled appointment. 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

105 Lexington Drive
Suite H
Madison, Mississippi 39110
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

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

HEALING HANDS
REHABILITATION SERVICES

LATE ARRIVAL 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, patients are asked to arrive 5-10 minutes before their scheduled appointment time. This will ensure that you receive your full treatment**.**

A grace period of 15 minutes will be permitted for unforeseen delays a patient may encounter while travelling to the clinic location for their appointment. If a patient arrives more than 15 minutes late for their appointment, the appointment will need to be rescheduled for a later date as the schedule permits. This process will ensure patient that do arrive on time are seen in a timely manner. With the exception of emergencies, it is expected that you keep and be on time for all of your scheduled appointments.

Thank you for your cooperation!!

Patient Name: _____

Patient Signature: _____

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

Date: _____

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: _____