Consent for Services

Patient Name: _____
Date of Birth: _____
Address: _____
Phone Number:_____ Email:_____
Daycare/School:_____
Physician Name:_____
Language preference:_____

Parent/Guardian Consent for Screening/Evaluation and Treatment

I hereby represent and acknowledge that I am the parent and/or legal guardian of the above-named patient, who is my lawful son/daughter. I give consent to authorize Hines Therapy Group to render appropriate screening, evaluation and therapy services to the client above named in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Hines Therapy Group in writing. In addition, Hines Therapy Group may terminate services by notifying me in writing or verbally.

Parent/Guardian Consent to Release Information

I give permission to Hines Therapy Group to communicate without restraint with the above-named patients physician, related health professionals, school officials, teacher, parents, family members, insurance companies, billing offices as deemed fit and in the sole discretion of Hines Therapy Group concerning the care and treatment of the above-named child.

Insurance Information

I authorize Hines Therapy Group to release all information needed for related Medicaid, MMA Healthcare Plans, or any other insurance holder, to the social security administration or its intermediaries or carriers. I permit a copy of my authorization to be used in place of the original. I hereby authorize payment if any, to be paid directly to Hines Therapy Group for medical benefits. If for any reason full payment is not received, I accept full responsibility to pay whatever charges remain. If do not pay such charges and it becomes necessary for you to file suit against me to collect such charges, I agree to pay for a reasonably attorney fee and the cost of the collection.

Release of Liability

I recognize that there are certain inherent risks when services are provided and I assume full responsibility for any harm or injury that may occur during the time of service. I hereby release Hines Therapy Group from all fault, liabilities, claims, demands, or take any action of that nature that may arise from services provided.

By signing below, I AGREE and CONSENT to the above mentioned.

Insurance: _____ ID #:_____

_____

Parent/Guardian Name Parent/Guardian Signature Date

Acknowledgement of HIPAA Privacy Notice

Hines Therapy Group is required by law to keep your health information and records safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider, including but not limited to medical history, test results, evaluation, plan of care, treatment notes and insurance information.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- This document will be valid until the discharge of the patient.

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information maybe used and shared.

I acknowledge that I have received a copy of Hines Therapy Group HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

I understand Hines Therapy Group cannot disclose my health information other than as specified in the notice.

I understand that Hines Therapy Group reserves the right to change the notice and the practices detailed therein. If so, you may obtain a revised copy by contacting our office.

_____	_____
Print Name of Client	Date
_____	_____
Parent/Guardian Name	Parent/Guardian Signature

Please Note: It is your right to refuse to sign this Acknowledgement.

HIPAA Privacy Notice Acknowledgement