**Helping Hands Therapy Services, PLLC**
**Virginia Beach, VA**
**Phone: 757-550-0725** **Fax: 888-306-7078**

www.helpinghandstherapyservices.com

# POLICIES AND INFORMED CONSENT

**CONSENT FOR EVALUATION AND TREATMENT:**
I ____________________________ do hereby consent to the evaluation and treatment by Helping Hands Therapy Services for myself or my minor child _____________________________ . I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment. I waive and waive and release all liability against Helping Hands Therapy Services, its employees, agents, officers and directors against any and all claims any way connected with my participation in my therapy program. I have the right to request information concerning the therapy plan of care and treatment. INITIALS:____________

**CONSENT FOR TREATMENT IN NATURAL ENVIRONMENTS:** **NA_____**
____________________________________(child's name) has my permission to participate in individual or group therapy/activities/sessions in natural environment settings as part of their physical. occupational, or speech therapy. I understand this presumes the presences of a wide variety of other people including other children, siblings, parents, students, and other community members. In addition to the natural play environments on location; my child may participate in therapy in the home, school, daycare/caregiver home, and community to maximize carryover of functional skills. I give permission for other caregivers to participate in my child's therapy including family members, siblings, nurses, babysitter/daycare provider. INITIALS:____________

**ADULT PARTICIPATION AND SUPERVISION:**
I understand that my participation in my child's therapy session is an essential part of their therapy and home program development. I agree to participate in their therapy sessions and understand that an adult must be present at all times while my child is receiving therapy. INITIALS:____________

**CONSENT FOR COMPLIMENTARY AND ALTERNATIVE THERAPY MODALITIES:**
Helping Hands Therapy Services utilizes a holistic approach in their services. This includes the use of complimentary and alternative medicine techniques such as dietary recommendations, lifestyle/wellness coaching, and aromatherapy/essential oils. I give consent for these practices to be utilized if requested/agreed upon and deemed appropriate for myself/my child. If utilized, I understand that the use of these modalities are complimentary and an integrative part of the therapy plan. I understand that the modalities are not intended to replace any currently prescribed medical treatments or care as ordered by my physicians. As with all therapy modalities, there is a risk of injury and side effects. If incorporated into therapy sessions, I agree to hold Helping Hands Therapy Services, PLLC and its employees, agents, contractors, officers and directors harmless from all claims. INITIALS:____________

**ACKNOWLEDGEMENT OF RECEIPT-NOTICE OF PRIVACY PRACTICES:**
I have received and reviewed the Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by requesting one at my provider location. INITIALS:____________

**DISCLOSURE AUTHORIZATION:**
Helping Hands Therapy Services is authorized to release any medical information required in the administering and applications for financial coverage for services required. Helping Hands Therapy Services may also send results of evaluation and recommendations to referring physicians and involved agencies for coordination and continuity of care. I have carefully completed this form and to the best of my knowledge it does not contain any false, incomplete or misleading information. Additionally, I give Helping Hands Therapy Services permission to share information with the following individuals/agencies: ________________________________

________________________________________________________________________________

________________________________________________________________________________

INITIALS:____________

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**ELECTRONIC COMMUNICATION**:
I give Helping Hands Therapy Services permission to share information electronically via text/email. While precautions are taken to ensure confidentiality, I understand that email/text communication is not encrypted and therefore could be read by a 3rd party. By providing my email address or text address, I am giving consent for electronic communication. Helping Hands Therapy Services does not charge for this service, but standard text messaging rates may be charged by my wireless plan. INITIALS:____________

Texting address/phone: ______________________________________

Email: ___________________________________________________

**FINANCIAL POLICY/ASSIGNMENT OF INSURANCE BENEFITS:**
I agree to the financial agreement with Helping Hands Therapy Services and agree to pay for services and/or treatment out-of-pocket as outlined in the "Financial Agreement" or the "Self-Pay Rate Fee Schedule" at the time services are provided. I understand that I am responsible for any and all additional fees services agreed to as described in the "Fee schedule." Furthermore, I understand that failure to make payment as stated in our policy for services rendered that go unpaid for more than 30 days will result in financial penalties, such as, but are not limited to, collection and legal fees. . I authorize the release of any medical or other information necessary to process claims. I give permission to bill my insurance and for the payment of benefits to be released directly to Helping Hands Therapy Services for all services provided and claimed. INITIALS:____________

**Medicare Patients**: I understand that if I do not have supplemental insurances, I will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible. INITIALS:______________

**CANCELLATION POLICY**:
There are times when families need to cancel therapy appointments due to illness, conflicting appointments, vacations or other family issues. Helping Hands Therapy Services requires at least 24 hour notice for cancelled appointments. This enables the therapist to make the best use of the cancelled time slot to see other patients. **I understand that if I do not show up for three appointments without calling, I may be discharged from therapy services. I also understand that I may be charged an out of pocket fee of $25 dollars for each scheduled appointment that is missed without notice. This fee is not reimbursable by insurance and will be billed directly to me.** INITIALS:____________

This form has been fully explained to me. I understand its contents and terms. My signature below certifies acknowledgement and acceptance of this consent form and all policies outlined in it.

| Client Name: | DOB: |
|---|---|
| Responsible Party Signature: | |
| Responsible Party Name/Relationship | Date: |