



When your child needs help, there is hope.

Occupational Therapy

Elite Therapy Services

★

Speech Therapy

Academy for Speech & Language

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Physical Therapy

Kids Therapy Specialties, LLC

Patient's Name: \_\_\_\_\_

Consent for Release of Records:

I, \_\_\_\_\_ (patient or representative as signed below), have been informed that each Hope Therapy practitioner is licensed and certified to provide therapeutic services according to the Plan of Care established by the therapist. I accept treatment from Hope Therapy practitioner(s). I can call Hope Therapy regarding my health care at 254-399-8255. This is not an emergency line. Call 911 in an emergency. It is the policy of Hope Therapy to protect all clinical records against loss, defacement, tampering, and use by unauthorized persons. I authorize Hope Therapy practitioner(s) to release medical information to my physician, the facility of my choice, payer source, or accrediting/regulatory/consulting organizations as appropriate. I authorize the release of the Plan of Care and Discharge Summary upon my transfer to another health care provider.

Financial Authorization:

I authorize benefits to be made on my behalf,

Bill Medicaid	Medicaid # _____	Effective Date: _____
Bill Primary Insurance	Insurance Co _____ ID # _____	Group/Policy# _____
	Insured's Name _____	Insured's D.O.B. _____
	Group/Employer Name _____	Plan Route Code _____

I am responsible to inform my practitioner(s) if my health plan benefits change within 7 days of the change. If HMO refuses coverage, I am responsible for the Hope Therapy practitioner(s) charges incurred. **I acknowledge that I am responsible for verifying and knowing my health insurance benefits for each service my child will receive. I will pay any service or supply charge not reimbursed by my insurance company on a monthly basis. I also acknowledge that I am responsible for my copay/coinsurance at the time of the visit.** I will pay all charges incurred on a monthly basis if I do not have insurance coverage. If a claim is denied for practitioner(s) services that have been submitted on my behalf, I hereby elect not to appeal the denial myself, but I authorize Hope Therapy practitioner(s) & contractors to resubmit the claim for me and represent me in any negotiations.

\_\_\_\_\_ Initials of Patient or Authorized Representative

Complaint/Hotline:

I have been notified of my right to voice a complaint and understand that I may first file a complaint with the Administrator or designee at 254-644-2423. I can also contact the Texas Department of Health, 1100 West 49<sup>th</sup> St/Austin, Texas 78756; 1-888-973-0022 in the event that I need information or if a complaint is not resolved. The line is open 24 hours a day. This includes a complaint regarding advance directives. Complaints regarding Utilization Review or HMO services can be made directly to TX Dept of Health Insurance at P.O. Box 149091; Austin, TX 78714; 1-800-252-3439.

Procedures:

I understand that it is my right and responsibility to be involved in my care/the care of my child and that I will be informed as to the nature and purpose of any technical procedure. I understand the recommended frequency of services. This frequency may change according to need. HIPAA – I acknowledge that I have been given the opportunity to review and offered a copy of the Hope Therapy "Notice of Privacy Practices" and consent to the Hope Therapy practitioner(s) use and/or disclosure of protected health information for payment, treatment, and agencies health care operations. I have also been offered a copy of and an explanation of the Patient Bill of Right.

\_\_\_\_\_  
Patient or Authorized Representative Signature/relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reason patient unable to sign

\_\_\_\_\_  
Agency Representative Signature

\_\_\_\_\_  
Date