8133 Ardrey Kell Rd Ste 104, Charlotte NC 28277
Phone: 704-413-0968 Fax: 704-626-6614
info@hpfstherapy.com

Patient Name: ___________________________________ **Date of Birth:** _____________

CONSENT FOR USE AND DISCLOSURE FOR TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I hereby consent for the use or disclosure of my child's identifiable heath information to carry out treatment, payment or health care operations. This includes assignment of benefits. Consent will be valid from ____________ to ____________.

This consent is authorized for the following health care providers:

____ Daycare staff
____ Child Care Provider
____ Attendant Family Member
____ Child Service Coordinator
____ PT, OT, SLP and CBRS on child's IFSP
____ Physican/Nurse
____ Nutritionist
____ School Staff
_X_ Office Ally and Navinet
____ Other___________________

I understand that I have the right to review this company's Notice of Privacy Practices.

I have received a copy, and read the Notice of Privacy Practices and understand its meaning. __________ (initial here)

I understand that I have the right to request that this provider restrict how protected health information is used or disclosed to carry out treatment, payment or healthcare operations. And that the provider is not required to requested restrictions.

I have the right to revoke consent in writing except to the extent that the provider has taken action prior to the revocation. I understand that this authorization is voluntary.

By signing this form, I understand that I am providing Handprints and Footsteps Pediatric Therapy, LLC with the right to bill my insurance provider for services.

____ _______________
Signature of Patient or Patient Representative **Date**

Printed Name of Patient's Representative: ____

Relationship to Patient: ____

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