

Care and Consent for Treatment

I hereby give written consent for occupational therapy treatment. I authorize Hands for Life Therapy to furnish treatment, which is considered necessary and proper in diagnosing or treating my physical condition.

I Acknowledge that I read and understand all the above statement Initial: _____

Notice of Privacy Practices

I hereby acknowledge that I have received a copy of Hands For Life Therapy Notice of Privacy Practices. By the way of my signature below, I provide Hands for Life Therapy with my Authorization and consent to use and disclose my protected health information for the purpose of treatment, payment and health care operations as described in the Notice of Privacy Practices.

I Acknowledge that I read and understand all the above statement Initial: _____

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Hands For Life Therapy. I understand that I am financially responsible for any balance. I also authorize Hands For Life Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date