HAND IN HAND THERAPY

Guiding little hands. Growing big skills.

Cancellation & No-Show Policy

Why Attendance Matters

Consistent attendance is important for your child's progress. Therapy builds on momentum and trust, and missing appointments can interrupt this growth. In addition, when a session is missed without notice, it prevents another child from receiving services during that time.

Cancellations

- We require **at least 24 hours' notice** to cancel or reschedule an appointment.
- Cancellations made **less than 24 hours before the session** may result in a **late cancellation fee of $50**, not billable to insurance.

No-Shows

- A **no-show** is when an appointment is missed without any notice.
- No-shows may result in a **$40 fee**, not billable to insurance.
- After **two no-shows or frequent cancellations**, we may place services on hold or discharge your child from the schedule.

We Understand Life Happens

We know children get sick, emergencies arise, and unexpected situations happen. Please communicate with us as soon as possible, we'll always work with you when we can.

If you have an ongoing schedule conflict, we're happy to discuss options to best support your family and your child's care.

How to Cancel or Reschedule

You may cancel by:

- Calling or texting: (910) 621-5905
- Messages received outside of office hours will be time-stamped for the next business day.

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Acknowledgment and Signature

I have read and understand the Cancellation & No-Show Policy for Hand in Hand Therapy. I agree to communicate proactively about appointments and accept responsibility for any applicable fees.

Child's Name: _____

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

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Consent for Evaluation and Treatment

Client Information

Child's Name: _____ Date of Birth: _____
Parent/Guardian Name: _____
Relationship to Child: _____
Phone Number: _____ Email Address:_____

Purpose of Evaluation and Treatment

Your child has been referred for therapy services to support their participation in everyday activities such as play, self-care, emotional regulation, and school-related tasks. The initial evaluation may include observations, parent interviews, standardized and non-standardized assessments, and interaction with your child.

If therapy is recommended, treatment will be tailored to your child's unique needs and goals. Sessions may involve movement, play-based tasks, sensory activities, fine motor practice, and home recommendations.

Consent for Services

I understand and agree to the following:

- I give permission for my child to participate in a therapy evaluation and, if indicated, in ongoing treatment services provided by Hand in Hand Therapy, PLLC.
- I understand that therapy services will be provided in a safe, supportive environment and are based on best practices in pediatric care.
- I understand that I can ask questions at any time and that I may withdraw consent at any time.

Benefits and Risks

Therapy may improve my child's independence, emotional regulation, coordination, strength, attention, and daily function. I understand that while benefits are expected, they are not guaranteed. Some therapy activities may be physically or emotionally challenging. My child will be supported at all times, and their well-being is a priority.

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Confidentiality & Privacy

Hand in Hand Therapy, PLLC complies with all HIPAA privacy regulations. Information shared during therapy will be kept confidential and only shared with others (e.g., physicians, teachers) with written permission. I have the right to access my child's therapy records upon request.

Parent/Guardian Responsibilities

- I will participate in communication and collaboration as needed.
- I understand the importance of regular attendance.
- I agree to follow any home strategies as recommended.
- I understand the clinic's cancellation and financial policies (provided separately).

In the event that in-person services are not possible or are supplemented with virtual services, I give my consent for my child to receive therapy via secure telehealth platforms. I understand:

- Telehealth may include video conferencing, phone communication, or digital resources.
- All efforts will be made to protect privacy and confidentiality, but there are inherent risks with online communication.
- I may stop or decline telehealth services at any time.

Initial here if you consent to telehealth services: _____

Consent Acknowledgement and Signature

I have read and understand the information above. I give consent for Hand in Hand Therapy, PLLC to evaluate and treat my child. I understand I can revoke this consent at any time in writing.

Parent/Guardian Signature: _____ Date:_____

Printed Name: _____

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Financial Agreement & Payment Policy

Our Commitment

At Hand in Hand Therapy, we are committed to providing high-quality care in a transparent and respectful environment. This agreement outlines our financial and billing policies to help avoid misunderstandings and ensure smooth communication regarding payment.

Insurance Billing & Payment Responsibilities

We are happy to bill your insurance provider on your behalf. However:

- **You are responsible for all charges not covered** by your insurance, including deductibles, co-pays, co-insurance, or services not covered.
- **Verification of benefits** is not a guarantee of payment.
- It is your responsibility to understand your insurance plan, obtain any required referrals or authorizations, and notify us of any insurance changes.
- Any balance not paid by insurance within 60 days may be billed directly to you.

Private Pay Rates

For clients without insurance coverage or those choosing to pay out-of-pocket:

- **Evaluation:** $150 per evaluation
- **Treatment Session (60 minutes):** $125 per session
- **Other services (e.g., reports, consultations):** $75 per hour

Payment is due at the time of service unless other arrangements have been made.

Attendance, Cancellations, and No-Shows

- We require **at least 24 hours notice** for cancellations.
- Cancellations made **less than 24 hours in advance** may result in a **$40 late cancellation fee**, not billable to insurance.
- **No-shows** (missed appointments without notice) may be charged a **$40 fee**.
- Repeated missed appointments may result in a pause or discontinuation of services.

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Payment Methods Accepted

We accept:

- Cash
- Credit/Debit Cards
- Checks (returned checks may incur a $30 fee)
- Zelle

Outstanding Balances

- Invoices are due upon receipt unless a payment plan is arranged.
- Accounts 30+ days past due may be subject to interest or collection efforts.
- Please speak with us early if you need a **payment plan or financial accommodation.** We're here to help.

Acknowledgment and Signature

I have read and understand the financial policy above. I agree to be responsible for payment of all services provided to my child by Hand in Hand Therapy, PLLC. I understand that I may ask questions or request a copy of this agreement at any time.

Child's Name: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Signature: _____ **Date:** _____

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HIPAA Notice & Consent Form

Your Privacy is Important: This notice describes how medical information about your child may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our Commitment to Your Privacy

At Hand in Hand Therapy, PLLC, we are committed to protecting the privacy of your child's health information. This information is called **Protected Health Information (PHI)** and includes things like medical records, evaluations, progress notes, and billing information.

How We May Use and Share Your Child's Information

We may use or share your child's health information:

- **For treatment:** To coordinate care with your child's doctors, teachers, or other therapists.
- **For payment:** To bill insurance companies or you directly for services provided.
- **For healthcare operations:** To improve services, train staff, or conduct internal reviews.
- **When required by law:** Such as for public health reporting or legal investigations.

We will never sell your information or use it for marketing without your written permission.

Your Rights as a Parent or Legal Guardian

As the parent or legal guardian, you have the right to:

- Review and request a copy of your child's records
- Request corrections to inaccurate or incomplete information
- Request restrictions on who we share information with
- Ask for confidential communication methods (e.g., email vs. phone)
- File a complaint if you believe your privacy rights have been violated

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Consent to Use and Share Information

By signing this form, you agree that:

- You have received and reviewed this Notice of Privacy Practices
- You give your consent for Hand in Hand Therapy, PLLC to use and share your child's health information for treatment, billing, and operations as outlined above
- You understand that you can revoke this consent at any time in writing

Contact for Questions or Complaints

If you have any questions about this notice or your rights, or if you believe your privacy has been violated, please contact:
Haley Bennett, OTD, OTR/L
(910) 621-5905 • haley@handinhandtherapy.org
You may also file a complaint with the **U.S. Department of Health and Human Services**. Filing a complaint will not affect your child's care.

Signature and Acknowledgment

I have read and understand the HIPAA Notice of Privacy Practices provided by Hand in Hand Therapy, PLLC. I give my consent for the use and disclosure of my child's protected health information for treatment, billing, and healthcare operations.

Child's Name: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Signature: _____ **Date:** _____

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Photo & Video Consent Form

We love celebrating children's progress and sharing creative, therapeutic activities to educate and inspire our community. We occasionally take photos or videos during sessions for the following purposes:

- **Educational use** (e.g., trainings, workshops)
- **Social media** and website content
- **Marketing materials** (flyers, brochures)
- **Clinic displays** (e.g., bulletin boards or visuals)
- **Clinical documentation** (stored privately for internal records only)

No names, identifying information, or diagnoses will be shared publicly without explicit permission.

Consent Options

Please initial next to each section:

___ Yes ___ No I give permission for **photos/videos to be used for marketing** (e.g., social media, website, brochures, presentations).

___ Yes ___ No I give permission for **photos/videos to be used for educational purposes**, including therapist training and professional development.

___ Yes ___ No I give permission for **photos/videos to be used for in-clinic displays** or visual supports (e.g., bulletin boards, therapy visuals).

___ Yes ___ No I give permission for **photos/videos to be used for internal clinical documentation** only (e.g., tracking progress, session notes).

Privacy Assurance

We respect your child's privacy. No photos or videos will be taken, stored, or shared without your consent. You may revoke this permission in writing at any time.

Acknowledgment and Signature

Child's Name: _____ **Parent/Guardian Name:**_____
Relationship to Child: _____
Signature: _____ **Date:** _____

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Name: _____ DOB:_____
Guardian Name: _____ DOB:_____
Relationship to client:_____
Phone #:_____ Email:_____
Address:_____

Primary Insurance Payer:_____ Insurance ID #:_____
Group #:_____ Group name:_____
Guarantor name, DOB, & SSN:_____
Address:_____
Phone #:_____

Secondary Insurance Payer:_____ Insurance ID #:_____
Group #:_____ Group name:_____
Guarantor name, DOB, & SSN:_____
Address:_____
Phone #:_____

To the best of my knowledge, the above information is accurate. I give Hand in Hand Therapy, PLLC the right to bill services as rendered.

_____ _____
Client / Legal Guardian Printed Name Relationship to Client

_____ _____
Client / Legal Guardian Signature Date

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Person providing information
Name:_____ Relationship to client_____

Referral information:
Referring physician:_____ Phone:_____

Child's name: _____ DOB:_____

Medical History:
Does your child have any diagnoses? Yes / No _____
Allergies: Yes / No _____
Medications: _____
Dietary considerations:_____
Hospitalizations, surgeries, accidents, illnesses:_____
_____

Gestational History:
Born at _____ weeks
Please describe any gestational complications:_____
_____
Please describe any birth complications:_____
_____

Treatment History:
(Circle any that apply) OT PT ST ABA
Comments: _____
_____
_____
_____
At what age (approximately) did your child:
Sit_____ Crawl_____ Walk_____ Run_____ Speak_____
Put words together_____ Use sentences_____
What are your child's strengths / motivating activities and toys:_____
_____
_____

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Parent concerns:

Please briefly describe any concerns you have in the following areas

Behavioral / Social: _____

_____

_____

Sensory: _____

_____

_____

Fine motor: _____

_____

_____

Gross motor: _____

_____

_____

Self-care: _____

_____

_____

Speech: _____

_____

_____

Safety awareness:_____

_____

_____

Executive function:_____

_____

_____

Academics:_____

_____

_____

Other: _____

_____

Thank you so much for taking the time to complete this form thoroughly. Your insights help us better understand your child's unique strengths, challenges, and needs. We truly value your partnership and look forward to working together to support your child's growth and success!