Pediatric Helping Hands Therapy, LLC
JMST for Kids, Inc.
MVPT for Kids, Inc.
Speech Tree, Inc.

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Confidential Client Intake Form

Patient Name: ____________________________ Gender: ☐ M ☐ F Ethnicity: _________________

Patient's DOB: ____________________________ Patient's SS #: ____________________________

Mother's SS #: ____________________________ Father's SS #: ____________________________

Address: ____

City, State: _________________________ Zipcode: ___________________

Home Phone Number: _________________________

Mother's Name: ____________________________ Father's Name: ____________________________

Mother's Cell #: ____________________________ Father's Cell #: ____________________________

Mother's Email: ____________________________ Father's Email: ____________________________

Mother's Work #: ___________________________ Father's Work #:___________________________

How were you referred to our office? (Select all that apply)

☐ Doctor/Pediatrician:________________________ ☐ School/Teacher:__________________________

☐ Daycare:________________________ ☐ Website ☐ Google Search ☐ Yelp ☐ Facebook

☐ Other: _________________________

Diagnosis/Concerns: ____

____

____

Current Physician's Name: ____

Address: ____

City, State: _________________________ Zipcode: ___________________

Phone Number: _________________________ Fax Number: _________________________

NPI: ___________________________________ TPI: ________________________________

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Medical History

Pregnancy/Delivery:
Pregnancy proceeded: ___Normally ___With complications
Delivery proceeded: ___Normally ___With complications
Prenatal care was: ___Received ___Not received
Delivery was: ___Vaginal ___C-Section
Length of Pregnancy: _______________
Child's length of hospital stay: _______________

Pregnancy Complications (Select all that apply):
___Eclampsia
___Gestational Diabetes
___Multiple Births
___Polyhydramnios
___Positive for Cytomegalovirus (CMV)
___Positive for Herpes
___Positive for Strep B
___Pre-eclampsia
___Pre-mature Labor
___Substance Exposure
___Toxemia
___Positive for HIV
___Other (Please specify): ______________________________________

Delivery Complications (Select all that apply):
___Abruptio Placenta
___Breech presentation
___Low birth weight
___Negative Vacuum
___Non-progressive/Unproductive labor
___Occiput posterior position (face up)
___ Placenta Previa
___ Premature Rupture of Membranes
___ Transverse presentation
___Prolapsed Cord
___Use of forceps
___ Uterine rupture
___Umbilical cord around neck
___Other (Please specify): ______________________________________

Birth Information:
Mother's age at time of birth: _____________
Birth Hospital: ____
Transferred to other hospital? ___Yes ___No Transfer hospital: ________________________________
Additional Comments: ____

Birth Weight: __________ Birth Height: __________
Apgar Scores: 1 minute_____ 5 minutes_____ 10 minutes_____

Multiple Child Pregnancies:
Number of live births: _____ Number of still births:_____
Additional Details: ____

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Complications following birth (Select all that apply)**:**

___Anemia of Prematurity
___Bronchopulminary Dysplasia (BPD)
___Cleft lip
___Cleft palate
___Club foot
___Cytomegalovirus (CMV)
___ECMO
___Failure to Thrive
___Hyperbilirubinemia
___Intrauterine Growth Retardation (IUGR)
___IVH Bleed Grade 1
___IVH Bleed Grade 2
___IVH Bleed Grade 3
___IVH Bleed Grade 4
___Jaundice
___Meconium Aspiration
___Necrotizing Enterocolitis
___Neonatal Hypoxia
___Oxygen dependency
___PDA
___Positive dependency
___Respiratory Distress Syndrome
___Respiratory Stridor
___Respiratory Syncytial Virus (RSV)
___Thrombocytopenia (low platelet count)
___Ventilator Dependency
___VP Shunt
___Other (Please specify): ___________________

Diagnosed/Suspected Syndromes: ____

Medications/Allergies

Current medications: ____

____

Allergies: ____

____

Current vitamins, herbs, minerals, homeopathic: ____

____

Hearing Testing:

Test results: ___Normal ___Abnormal ___Never tested

Last test date: ______________________

Results: ____

Vision Testing:

Test results: ___Normal ___Abnormal ___Never tested

Last test date: ______________________

Results: ____

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Physician	Specialty	Reason	Last Date of Visit

Surgery/Procedure/Diagnostic Tests	Details/Results	Date

Medical Conditions (Select all that apply)**:**

___Allergies
___Arteriovenous Malformation (AVM)
___Anoxic brain injury
___Asthma/Respiratory breathing problems
___Autism
___Baclofen pump
___Cerebral Palsy
___Cerebral Vascular Accident (CVA)
___Chronic ear infections
___Colic
___Constipation
___Diarrhea
___Down Syndrome
___Hip subluxation (Degrees: ________)
___ Hydrocele

___Laryngomalacia
___Muscular Dystrophy
___Osteoporosis
___Periventricular Leukomalacia
___Reflux
___Seizure condition
___Scoliosis (Degrees:________)
___Sleep disorder
___Sleep problems
___Shunts
___Torticollis
___Traumatic Brain Injury (TBI)
___Tube feeding
___Tubes in ears
___Vagal nerve stimulator

Other medical/orthopedic conditions: ____
____
____

Additional comments: ____
____

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Developmental History

Motor/Play

When did the child begin:

Bringing both hands to mouth? _______________

Buttoning pants/shirts? _______________

Come to sitting from lying with assistance? _______________

Creeping or crawling alone? _______________

Fully toilet trained? _______________

Grabbing a toy? _______________

Holding head up alone? _______________

Pulling self to standing position? _______________

Rolling over? _______________

Self-bathing? _______________

Self-dressing? _______________

Sitting alone without support? _______________

Standing unsupported? _______________

Tying shoes? _______________

Walking with support? _______________

Walking unaided? _______________

Zipping/unzipping jacket? _______________

Comments/Concerns: ____

____

____

Is the child:

___Right handed

___Left handed

___No hand preference

Are there handwriting concerns? ___Yes ___No

The child primarily gets around the home by: ____

The child's favorite toys and play activities are: ____

____

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Description of the child (Select all that apply)**:**

___Active
___Affectionate
___Aggressive
___Calm
___Cautious
___Curious
___Demanding
___Difficult to comfort
___Distractible
___Fearful
___Fearless
___Fussy
___Insecure
___Motivated
___Passive
___Persistent
___Playful
___Shy
___Stubborn
___Withdrawn
___Other (Please specify): ____

<u>Sensory/Socio-emotional</u>

Sensory Processing/Regulation (Select all that apply)**:**

___Avoids getting messy
___Seeks out (craves) touch or movement
___Stumbles or falls frequently
___Appears awkward or less coordinated
___Flaps hands
___Allows brushing of teeth
___Bangs on surfaces; bangs or hits head
___Fatigues quickly
___Has self-abusive behaviors
___Resists certain tasks or environments
___Spins things or self
___Is sensitive to lights, sounds, or noise
___Sleeps a lot
___Resists touch
___Walks on toes
___Lines up toys or objects
___Seeks out (craves) visually stimulating objects
___Seeks out (craves) stimulating sounds
___Resists certain movements (e.g. bouncing, swinging)
___Has difficulty figuring out how to move body
___Can't tolerate certain textures (e.g. clothing, food)
___Uses too much pressure to touch or hold things
___Has difficulty transitioning between activities
___Has difficulty falling asleep
___Has difficulty remaining asleep through the night
___Appears lethargic or sleep all the time
___Has poor sense of body in space
___Seeks support on furniture, walls, people, etc.
___Demonstrates stiff or rigid movement patterns
___Hyper-focused on specific tasks, people, objects
___Other (Please specify): ____

Social/Emotional Skills (Select all that apply)**:**

___Is easily distracted
___Calms self easily
___Gets angry/frustrated easily
___Is aggressive towards others
___Prone to emotional outbursts
___Doesn't allow others to join in play
___Has difficulty making friends
___Plays with peers
___Only plays with adults
___Prefers to play alone
___Has difficulty with separations
___Has poor eye contact
___Other (Please specify): ____

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Feeding

Describe any current feeding problems: ____

____

Food preferences: ____

Food dislikes: ____

When did the child begin:

Using a bottle_______________

Using a pacifier_______________

Eating baby food_______________

Eating junior food_______________

Eating table food_______________

Drinking from a cup_______________

Using a straw_______________

Stop using a bottle_______________

Stop using a pacifier_______________

Using utensils to eat_______________

Holding own bottle/cup_______________

Self-feeding_______________

Current feeding adaptations:

___Thickened liquids: ____________________________________

___Adapted utensils: ____________________________________

___Adapted seating: _____________________________________

___Calorie supplements: __________________________________

___Tube feeding: Amount __________; Times per day __________

Breastfeeding:

___Currently: Times per day __________

___Weaned: At age: _________

___Never

Areas of difficulty:

___Chewing

___Communication needs

___Transitioning between foods

___Jaw shifts/slides/juts

___Drooling

___Swallowing

___Understanding words

Speech/Language

Communication skills:

Does the child

Have speech that is understood by most people? ___Yes ___No

Respond correctly to yes/no questions? ___Yes ___No

Follow simple instructions? ___Yes ___No

Respond when name is called? ___Yes ___No

Stutter? ___Yes ___No

Recognize objects, people, and places? ___Yes ___No

The child's primary method of communication is ___Verbal ___Non-verbal

Is an augmentative communication device used? ____

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

When did the child begin:

Babbling ________________ Putting two words together ________________

Saying first words ________________ Using short sentences ________________

Naming familiar objects ________________

What were the child's first words? ____

Primary method of verbal communication (Select all that apply)**:**

___None ___2 word phrases

___Vocalizations ___Complete sentences

___Single word phrases

Primary method of nonverbal communication (Select all that apply)**:**

___Facial expression ___Gestures

___Body language ___Pointing

___Sign language ___Eye gaze

Communication concerns: ____

<u>**Home Environment**</u>

Child lives with:

___Birth mother ___Birth father ___Step mother ___Step father ___Grandmother ___Grandfather

___Siblings (Ages:___________________________) ___Other relative: ______________________________

___Legal guardian: __________________________

Comments/Other details: ____

Adoption (If applicable)**:**

Age of child at adoption: _____

Details of adoption: ____

Type of home:

___Single level home ___Assisted living facility

___2 level home ___Skilled nursing facility

___Ground floor apartment ___Group home

___Upper level apartment ___Other: __________________________________

Accessibility:

___Stairs to enter home: How many? _______ Handrail? _______

___Ramp to enter home

___Stairs inside home: How many? _______ Handrail?

Bedroom on ___Main level ___Upper level

Bathroom on ___Main level ___Upper level

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Equipment (Select all that apply)**:**

___Braces ___Walker ___Stander ___Manual wheelchair ___Power wheelchair ___Hoyer lift
___Weighted vest ___Hand splints ___Track system ___Other:____________________________________

Do you currently perform a home program with your child (e.g. stretching, strengthening, brushing protocol)? ___Yes ___No
If so, please describe: ____
____

Is the child involved in any community groups or sporting activities? ___Yes ___No
If so, please describe: ____
____

Therapy/School History

Grade in school: _______________ Where: ____
Does your child have an IFSP?: ___Yes ___No
Does your child have an IEP from school? ___Yes ___No
Has your child had a psychological or neuropsychological evaluation completed? ___Yes ___No

Service	Group/Individual	Status	Frequency	Location/Setting
Assistive Technology				
Audiology				
Behavior Therapy				
Developmental Therapy				
EI Services				
Intensive Suit Therapy				
Vision Therapy				
Nutrition				
Occupational Therapy				
Physical Therapy				
Social Work				
Speech/Language Therapy				
Developmental Follow-Up Clinic				
Other: _______________				
Other: _______________				

Comments/Additional Details:____
____
____

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU/YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

USES AND DISCLOSURES
We may use or disclose your child's protected health information without your written consent, written authorization, or oral agreement for the following purposes:
Treatment: For example, we may use your child's health information within our office to provide healthcare services to your child or we may disclose your child's health information to another provider if it is necessary to refer you to them for services.
Payment: For example, we may disclose your child's health information to a third party such as an insurance carrier, an HMO, PPO, or other third party in order to obtain payment for services provided to your child.
Healthcare Operations: For example, we may use your child's health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your child's protected health information without your written consent, written authorization, or oral agreement under the following circumstances:

1) If we provide services to your child in an emergency treatment situation.
2) If we are required by law to provide services to your child and we are unable to obtain your consent after attempting to do so.
3) If we need to notify, or assist in the notification of, a family member, personal representative, or another person responsible for your child's care of his/her location and/or general condition.
4) If we are required by law to disclose your child's health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury, or disability.
5) If we are required by law to disclose your child's health information to a city, state, or government authority and/or any other agency organized to receive reports of abuse, neglect, or domestic violence, or response to a court order or subpoena, and/or to a coroner, medical examiner, or funeral director.
6) If we are required to disclose your child's health information to the Food and Drug Administration.
7) For research purposes.
8) If we, in good faith, believe that the use or disclosure of your child's health information is necessary to prevent a serious threat to the health or safety of others.

With the exception of the above stated circumstances, any use or disclosure of your child's health information will be made only with your written authorization. Your written authorization may be revoked, in writing, at any time except to the extent that we have already provided services or taken action in reliance on your authorization.

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Your Rights

RIGHT TO REQUEST RESTRICTIONS

You have the right to request restrictions on certain uses and disclosures of your child's health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS

You have the right to receive confidential communications concerning your child's health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your child's health information at a place other than your home address or by means other than regular mail.

RIGHT TO INSPECT AND/OR COPY

You have the right to inspect and/or copy certain health information for as long as that information remains in your child's record. Your request to inspect and/or copy your child's health information must be made in writing to our Privacy Official.

RIGHT TO AMEND

You have the right to request that we amend certain health information for as long as that information remains in your child's record. Your request to amend your child's health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

RIGHT TO RECEIVE AN ACCOUNTING

You have the right to receive an accounting of our disclosures of your child's health information made up to six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official.
The accounting will not include the following disclosures:

- Disclosures made to carry out treatment, payment, and healthcare operations.
- Disclosures made to you.
- Disclosures made in our facility directory.
- Disclosures made to individuals involved with your child's care.
- Disclosures made for national security or intelligence purposes.
- Disclosures made to correctional institutions or law enforcement officials.
- Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

RIGHT TO RECEIVE NOTICE

You have the right to receive a paper copy of this notice, upon request.

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your child's protected health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all the protected health information we maintain. If we make a change in the terms of this notice, we will notify you in writing and provide you with a paper copy of the notice, upon request.

Complaints

You may submit a complaint to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint against us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

Attn: **Magda Jimenez, Privacy Official**
4918 Milam St
Houston, Texas 77006

How to Contact Us

If you would like further information about our privacy practices, please contact:

Magda Jimenez, Privacy Official
Telephone Number: (713)-807-1131

Effective Date of Notice: August 1, 2006

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Authorized Release of Protected Health Information (PHI)

Please list all professionals who have regular contact with your child (i.e. Pediatricians, Developmental Specialists, Therapists, Teachers, Nannies, Caregivers, etc.)

Name of Person/Entity	Phone #	Place of Employment	Date of Release	Authorization to Release PHI

___________________________________ __________________

Signature of Parent/Legal Guardian Date

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Authorizations & Releases

Patient Name: ______________________________ Patient DOB: _____________________

All authorizations and releases of information on this form are valid for the duration of treatment unless the client cancels the authorization by written notice.

CONSENT FOR TREATMENT

I, the undersigned, voluntarily consent to the rendering of care, including treatment, evaluation, and home program. I understand that I am under the care and supervision of the performing provider.

_______________________________________ _______________________

Printed name of Parent/ Guardian Date

_______________________________________ _______________________

Signature of Parent/Guardian Date

AUTHORIZATION / ASSIGNMENT TO PAY BENEFITS

I, the undersigned, hereby authorize payment to my child's therapist(s) and/or Pediatric Helping Hands Therapy of the medical benefit, if any, otherwise payable to me for the services. I understand that I am financially responsible for my child's treatment charges and supplies including co-pay, deductibles, and co-insurance amounts not covered by this assignment of benefits.

_______________________________________ _______________________

Signature of Parent/Guardian Date

AUTHORIZATION TO DISCUSS CLINICAL CARE

I, the undersigned, hereby authorize my child's therapist(s), their employee, and/or their contractor to discuss clinical care with other therapists and professionals associated with Pediatric Helping Hands Therapy. I also realize that students from various local universities may attend Pediatric Helping Hands Therapy to observe treatment strategies with my child or to perform a supervised internship that may involve my child.

_______________________________________ _______________________

Signature of Parent/Guardian Date

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

RELEASE OF INFORMATION

I, the undersigned, hereby grant consent to Pediatric Helping Hands Therapy to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations.

Our Notice of Privacy Practices for Protected Health Information provides more detailed information about how we may use and disclose this protected health information. You have the legal right to review our Notice of Privacy Practices for Protected Health Information before you sign this release, and we encourage you to read it in full.

Our Notice of Privacy Practices for Protected Health Information is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (713)-807-1131. You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or healthcare operations. We are not required by law to grant your request; however, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this release in writing, except to the extent that we may have already used or disclosed your protected health information in reliance on your consent.

______________________________________	____________________
Printed name of Parent/ Guardian	Date
______________________________________	____________________
Signature of Parent/Guardian	Date

AUTHORIZATION FOR VIDEO/PICTORIAL CLINICAL RECORDS

I, the undersigned, authorize my child's therapist, and/or their employee, and/or their contractor to videotape or take photographs of my child for clinical evaluation and record keeping purposes.

______________________________________	____________________
Printed name of Parent/ Guardian	Date
______________________________________	____________________
Signature of Parent/Guardian	Date

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a Notice of Privacy Practices for Protected Health Information (PHI) which provides a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:

___The right to review the notice prior to signing this consent.

___The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

____	______________________
Printed name of Patient	Date
____	______________________
Printed name of Parent/ Guardian	Date
____	______________________
Signature of Parent/Guardian	Date

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Date: ______________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy for Pediatric Helping Hands Therapy, LLC, JMST for Kids, Inc., MVPT for Kids, Inc., and/or Speech Tree, Inc. A copy of the signed and dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment records to be sent to other attending physicians or therapists in the future.

____ ________________________
Printed name of Patient Patient Date of Birth

____ ________________________
Signature of Patient or Parent/Guardian Date

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS YOUR CHILD'S MEDICAL TREATMENT INFORMATION AND/OR BILLING RECORDS. (This includes step parents, grandparents, educators, and any caretakers who may require access to this patient's records.)

Name: ______________________________Relationship:_________________ ___Medical ___Billing

Name: ______________________________Relationship:_________________ ___Medical ___Billing

Name: ______________________________Relationship:_________________ ___Medical ___Billing

Name: ______________________________Relationship:_________________ ___Medical ___Billing

I authorize contact from this office to CONFIRM MY CHILD'S APPOINTMENTS, TREATMENT, AND BILLING INFORMATION VIA:

___Cell phone: ______________________
___Home phone: ______________________
___Work phone: ______________________
___Email Address: ____
___ All/Any of the above

I authorize contact from this office to convey INFORMATION ABOUT MY CHILD'S MEDICAL HEALTH VIA:

___Cell phone: ______________________
___Home phone: ______________________
___Work phone: ______________________
___Email Address: ____
___All/Any of the above

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Client Cancellation Policy

Our primary focus is to improve the quality of services we provide our clients and their families. Consistent attendance is necessary to maximize progress. Furthermore, insurance companies are holding us accountable to provide consistent therapy or coverage may no longer be available. We have instituted a fair cancellation policy as follows.

POLICY

Pediatric Helping Hands Therapy must be informed of any cancellations at least 24 hours prior to the scheduled appointment. We have a phone system that allows you to leave detailed messages for your therapist or the office staff. Failure to contact Pediatric Helping Hands Therapy with at least 24 hours notice will result in a $50.00 fee, payable within 30 days.

Chronic cancellations (3 or more cancellations or 2 "no-shows" within a 2-month period) may lead to discharge by your therapist.

CHRONIC CANCELLATION PROCEDURE

When a client is not in compliance with this policy, a staff member will contact the family to discuss the reason(s) for cancellation, attempt to alleviate the problem, and offer support in improving attendance.

Should services be terminated, the family will have the option to be placed on our waiting list and may resume therapy when an opening becomes available. All outstanding fees and bills must be settled prior to restarting therapy.

____ ________________________

Printed name of Parent/ Guardian Date

____ ________________________

Signature of Parent/Guardian Date

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Irrevocable Assignments and Financial Responsibility

___I hereby authorize all responsible parties to pay directly to Pediatric Helping Hands Therapy, all benefits and amounts due for services rendered by Pediatric Helping Hands Therapy staff.

___I hereby authorize all responsible parties to pay directly to JMST for Kids, Inc. all benefits and amounts due for services rendered by Jodie Holleman-McCarty.

___I hereby authorize all responsible parties to pay directly to Speech Tree, Inc. all benefits and amounts due for services rendered by Heike A. Tiensch and her staff.

___I hereby authorize all responsible parties to pay directly to MVPT for Kids, Inc. all benefits and amounts due for services rendered by Maria Varela.

I understand that if the above referenced service providers are not paid in full by proceeds of paid benefits, then this assignment does not release my obligation and liability for payment for all services and items provided to me or the below referenced patient. In the event that no benefits are paid by the responsible parties, then I agree to pay the above referenced service provider(s) for all charges in excess of the benefits paid.

All payments will be made payable to the designated service provider at:

4918 Milam St
Houston, Texas 77006

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding, and I have signed this document freely and without inducement other than the rendition of services by the designated service provider(s).

____	_________________________
Printed name of Patient	Date
____	_________________________
Signature of Patient's Authorized Guardian	Date

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Recurrent Payment Authorization Form

Your payment can be scheduled to automatically charge your Visa, Master Card, American Express, or Discover Card.

Benefits of recurring payments:

- Convenience: Saves you time, postage, and worry.
- Payment is always on time (even if you are out of town).

How recurring payments work:

You authorize Pediatric Helping Hands Therapy to make charges to your credit card for rehabilitation services. You will be charged the amount owed each month for services provide and/or claims adjudicated by insurance during the billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as "ACH Debit". You agree that no prior-notification will be provided unless the date changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the following information:

I, ______________________________________, authorize ____________________________________ to
(Full name)
charge the credit card indicated below for rehabilitation therapy service charges at the time services are rendered.

Billing address: ____

City, State: ____________________________ Zip Code:_____________________

PhoneNumber: __________________________ Email: ____

Credit Card Information

___Visa ___American Express
___Mastercard ___Discover

Cardholder Name: ____________________________________
Account Number: ____________________________________
Expiration Date: _____________
CCV#: _________

Signature:____________________________________ Date: __________________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the above referenced business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, the funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF), I understand that there may be another attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company so long as the transactions correspond to the terms indicated in this authorization form.

4918 Milam St
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Photography Release Consent Form

Pediatric Helping Hands Therapy recognizes the need to ensure the welfare and safety of all individuals taking part in any activity associated with our company.

In accordance with our child protection policy we will not permit photographs, video or other images of young people to be taken without the consent of the parents/guardians. As your child will be taking part in therapy at our facility, we would like to ask for your consent to take photographs/videos that may contain images of your child.

It is likely that these images may be used as

- a record of therapeutic progress
- a description of therapeutic procedures, exercises, or activities
- marketing via social media (Facebook, Instagram, and/or our company website)
- records of activities or events in published materials

Pediatric Helping Hands will take all steps to ensure these images are used solely for the purposes they are intended. If you become aware that these images are being used inappropriately you please inform our staff immediately.

We would be grateful if you would return this form to Magda Jimenez as soon as possible.

I,________________________________ ☐ **Consent to** ☐ **Do not consent to** Pediatric Helping Hands using photographs or videos of my child, ______________________________, for any lawful purposes including record keeping and printed/online marketing purposes.

___________________________ ________________________

Parent/Guardian Signature Date