Lifting Spirits Therapy Services, Inc.
Patient Consent & Acknowledgement Form

Patient First Name	Middle	Last
Insurance Name	Insurance Number	Date of Birth

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
I have been given a copy of Lifting Spirits Therapy Services, Inc Notice of Privacy Practices and understand these rights. I also understand that it is my responsibility to notify the Privacy Officer (Yuridia Garza, MS OTR/L) in writing of any restrictions to my patient file. Forms are available through the Privacy Officer upon request.

CONFIDENTIAL COMMUNICATIONS
I hereby consent and grant permission for Practitioner's employed by Lifting Spirits Therapy Services, Inc to discuss my medical treatment for occupational therapy services with my referring physician, primary care physician, and/or rehabilitation team relating to my care and treatment. I also understand that it is my responsibility to notify the Privacy Officer in writing of any restrictions to my patient file. Forms are available through the Privacy Officer upon request.

OFFICE PROCEDURES
I hereby give consent to Lifting Spirits Therapy Services, Inc to provide occupational therapy treatment and service (s) the assigned Provider may deem necessary. I hereby understand that I am responsible for payment of charges and that payment is due at the time of service, or I hereby assign insurance benefit to be paid directly to Lifting Spirits Therapy Services, Inc for professional fees. I understand that I am responsible for charges not covered by my insurance policy. I understand that I am responsible for a fee of $25 for any returned check.

RELEASE OF INFORMATION & AUTHORIZATION
I hereby consent and permit a copy of this authorization and assignments to be used in place of this original signed document. I understand that this original will be placed in my patient file to be kept at the medical provider's office. I hereby authorize any practitioner examining and/or treating me, to release to any third party (such as an insurance company or governmental agency) any medical information and records concerning the diagnosis and treatment when requested for use in determining payment of claims. I understand that this is a Lifetime Release of Information unless I have placed restrictions in my patient file and have completed the necessary forms. I hereby consent and authorize Lifting Spirits Therapy Services, Inc to file medical claims for treatment, electronically or manually, to my insurance carrier (s) for services rendered to me.

PHOTOGRAPHY CONSENT FORM / RELEASE FOR MINOR CHILDREN (Under 18)
I, (print name)_____, parent or official guardian of (child's name)_____hereby grant permission to Lifting Spirits Therapy Services, Inc and its representatives, to take and use: photographs and/ordigital images of **my child** for use in marketing and/or educational materials as follows: printed publications or materials, electronic publications, and/or company web site including facebook company page. I agree that my child's name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions and shall be the property of Lifting Spirits Therapy Services, Inc.

ASSIGNMENT OF BENEFITS
I hereby consent and authorize payment to be paid directly to provider, Lifting Spirits Therapy Services, Inc, for services rendered for any services or treatment. Any services for which assignment is not accepted are acknowledged as being my full and complete financial responsibility.
I have read, understand and agree to all the above.

Parent Printed Name: _____
Patient/Parent Signature_____ Date _____

P.O. Box 1071 Gainesville, GA 30503 (678) 908 - 7057