Hand Led Therapy Registration Form

Check Therapy Service(s): ☐ Occupational Therapy ☐ Speech-Language Therapy

Child's Name: _____

Child's Date of Birth: _____

Child's School: _____

Child's Grade: _____

Child's Teacher: _____

Home Address: _____

Zip Code: _____

Parent Email: _____

Parent Phone: _____

Payment Information

Print Name as it Appears on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

CREDIT CARD AUTHORIZATION & 8-HOUR CANCELLATION POLICY

I understand Hand Led Therapy requires a minimum 8 hours' notice for cancellations. Appointments missed or cancelled late will be charged the full session fee. I authorize Hand Led Therapy to securely store my credit card on file and automatically charge it for all private-pay services rendered and late cancellation/no-show fees. This authorization remains valid until revoked in writing.

CONSENT FOR TREATMENT & PARENTS' BILL OF RIGHTS COMPLIANCE (FL STATUTE § 1014.06)

By checking the box and signing below, I certify that I am the legal parent/guardian of the minor patient and provide my explicit, one-time written consent for Hand Led Therapy to provide speech-language pathology and/or occupational therapy services. I authorize ongoing screenings, formal evaluations, treatment, re-assessments, and telehealth sessions designed by a licensed SLP or OT and potentially administered by a certified/licensed therapy assistant (SLPA/COTA) under direct, lawful supervision. I explicitly authorize services to be delivered in an individual and/or group setting when clinically indicated to target peer-based, social, motor, or language goals. I acknowledge that in a group setting, my child's behaviors and therapy progress will naturally be visible to peer participants, and I accept this risk of incidental privacy disclosure. I agree that our family will maintain strict confidentiality regarding the identities and behaviors of any other children participating in the group. I acknowledge that under the Florida Parents' Bill of Rights, I retain the absolute right to access all clinical records, participate in care planning, and revoke this consent in writing at any time. This authorization remains continuously valid for the entire duration of care unless explicitly revoked. In an acute medical emergency during a session, I authorize the practice to arrange necessary emergency care or transport.

☐ **I have read, understand, and explicitly consent to the terms of treatment above.**

☐ **I agree to the financial terms outlined above and authorize the secure storage and automatic billing of my credit card.**

Parent Signature: _____ Date: _____

Rates:
Screening: $25 (Credited towards Evaluation)
Evaluation and Annual Re-Evaluation: $200 (With OWLS/TILLS/CAS-2: $375)
30 Minute Therapy Session: $60

By completing this form, you permit Hand Led Therapy to collaborate with your child's school and teachers regarding results and progress. Please save and email this completed form to eileen@handledtherapy.com.