

“We look forward to the opportunity to serve you and your child.”



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Release to send text and/or email appointment reminders

By initialing below, I confirm and authorize Southern Pediatric Therapy Clinic, Inc. to provide text message and/or email reminders to provided cell phone number and/or email address. I understand that there will be personal appointment information that is protected under HIPPA law. I understand the HIPPA law and accept responsibility for these reminders.

Patient Initials

Date

Confirm receiving copy of non-discrimination policy

By initialing below, I confirm that I have received a written copy of Southern Pediatric Therapy Clinic's Non-Discrimination Policy. I have read and completely understand the policy and have been given opportunity to clarify any misunderstanding.

Patient Initials

Date

Confirm understanding of formal discharge assessment requirement

It is a medical necessity per your insurance provider that you complete a formal in person discharge assessment during your last scheduled appointment. An unplanned “self discharge” without completing a formal discharge assessment is not covered without providing documented extreme circumstances. By initialing below, you are acknowledging understanding of this policy and are pledging your assurance that you will make every available effort to complete your agreed upon prescribed plan of care as well as completing a formal discharge assessment upon your last scheduled appointment.

Patient Initials

Date

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Southern Pediatric Therapy Clinic. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPPA privacy regulations.

Patient Initials

Date