Patient Name ___________________________________

Consent to Treat

Initial _____ I, _____________________________(parent/guardian), give my consent for TherapyWorks 4 Kids, LLC to provide Occupational, Speech, and/or Physical Therapy treatment (OT, ST, PT) as may be beneficial in the professional judgment of the child's therapist(s) and primary care physician. I am aware that no guarantee has been made as to the effect of OT, ST, or PT on my child.

Initial _____ My child has my permission to participate in a natural environment setting during therapy sessions. I understand that this presumes the presence of a wide variety of other people including other children, siblings, parents, professionals, volunteers, or students. In addition to the natural play environment on location; my child may participate in therapy in the home, school, and community to maximize carryover of functional skills.

Initial _____ I am aware that gross motor play is often encouraged during therapy. Use of swinging, running, climbing, and jumping assist with a variety of skills and performance components the therapist may need to address. I consent to use of gross motor play with my child and acknowledge that TherapyWorks 4 Kids, LLC and its' employees are not responsible for any accident/injury that occurs to my child as a result of this type of play.

Initial _____ I am aware that persons not listed on the prescription are not allowed into the treatment areas and will be under my direct supervision at all times. TherapyWorks 4 Kids, LLC is not responsible for any accident/injury that occurs as a result of unauthorized or unsupervised use of the facility and/or equipment.

I authorize photographs/video to be used for the following purposes: (**Parents ONLY initial approved purposes**)

Track your child's therapy progress __________ Display on website __________
Display in clinic __________

Initial _____ I have been provided a copy of the Notice of Privacy Practices.

Attendance Policy: (please read carefully)

1. Consistent therapy attendance is required by TherapyWorks and is critical for your child's success. Missed visits need to be rescheduled in order to comply with your child's plan of care & physician order. If an appointment is rescheduled, the cancellation will not be considered a missed visit. This appointment may not be with your regular therapist.

2. Your child may be discharged from therapy or taken off of the permanent caseload of the therapist after more than 1 no-show (does not call or cancels with less than 24-hour notice) and/or cancels more than 3 visits without re-scheduling them. If you do not cancel before 4pm on the business day PRIOR to the child's appointment (and there is no medical reason) you will be charged a $50 no-show fee that is due before the child is seen for their next appointment.

3. If you arrive 15 minutes or more past the scheduled appointment time, your therapist may have been assigned to another child and your appointment may be canceled. A consistent pattern of late arrivals will result in discharge from therapy.

4. TherapyWorks allows caregivers to leave the premises during your child's treatment session as long as we have an emergency phone number to reach you at. You will need to arrive 10 minutes prior to the end of your child's therapy so that the therapist may discuss the session & any home programming needs. You are responsible to update your phone number with TherapyWorks 4 Kids if it changes. A $10 late fee will be charged if you fail to pick up your child on time.

5. I am aware that if we do not comply with the home exercise program and/or comply with attendance that insurance companies may no longer authorize therapy services and the child will be discharged from therapy due to non-compliance.

6. TherapyWorks strives to protect patient & family privacy. To do this, we limit the amount of family brought into the treatment rooms. If you would like to come back to observe your child's therapy, we ask that you set this up in advance so we can make sure there is a private room available. Please understand that there may be times your therapist will request that you be present for educational purposes.

I acknowledge that I understand the above policies & that my compliance is required in order to continue to receive services.

Parent/Guardian (print name): ___________________________ (signature): _______________________________ (date): ___________