Consent Form

I understand that my records are protected under state and federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time. I understand that information is limited to staff whose work assignments reasonably require access to my data for the purposes specified as related to the services provided. I give permission for The Therapy SP/OT, LLC to observe, test, or treat my child for speech therapy and/or occupational therapy purposes. I also give permission for individuals that work with my child at this facility to collaborate and share information related to the above stated purposes.

❑ I give permission for The Therapy SP/OT to bill my insurance company for services rendered.

❑ I give my permission to video my child solely for the purpose of confidential therapeutic purposes (such as evaluations, social skill group learning or for parent education and review).

❑ I give permission for professionals at The Therapy SP/OT to contact me via email, understanding that sensitive information and HIPAA regulated information will not be transferred this way, unless I request to do so in writing or in an email.

❑ I give permission for therapists to provide verbal updates in the waiting room following each treatment session, understanding that this may be done in the presence of other clients and families. If at any time I request a private conversation without the presence of other individuals, this request will be granted.

❑ I give permission for my child's therapy sessions to be observed by students considering the field of service my child is receiving. I understand the student will sign a non-disclosure agreement.

_____ _____

Parent/ Guardian / Legal Representative Signature Date

Please list any guardians/stepparents/nanny/grandparents that we have permission to speak with regarding any services provided by The Therapy SP/OT (If there is a parent or other party that we are not permitted to communicate with please discuss this with a clinic manager).

Name: _____

Acknowledgement of Receipt of Privacy Policies

I have been informed of and received a copy of The Therapy SP/OT's policies regarding my Protected Health Information as well as email risks and how it will be used. A copy of our policy is available in the waiting area for me to review as needed. I understand that written consent may be required for some requests.

_____ _____

Print Name Date

_____

Signature