SENSORY CONNECTIONS | PEDIATRIC OCCUPATIONAL THERAPY

Consent for Occupational Therapy and Financial Responsibility

I, _____ am seeking occupational therapy with Sensory Connections: Pediatric
(Parent/Guardian Name)
Occupational Therapy, LLC. I consent to an evaluation and treatment of _____.
(Child's Name)

Frequency and duration of the service is contingent upon the results of the evaluation, the recommendation of the therapist, and no specific outcomes are promised. I understand that the care and treatment falls within the scope of, without limitation, occupational therapy practice as defined by the State of Indiana and the American Occupational Therapy Association. I understand that the practice of medicine, including occupational therapy, is not an exact science and that treatment will involve physical participation on the part of the Client which may involve risks of injury.

I acknowledge that no warranty or guarantee has been made to me regarding the result of evaluation or treatment.

Signature Parent/Guardian _____ Date _____

Printed Name _____

Relationship to Client _____

Witness Signature:_____ Date _____

Financial Responsibility

RESPONSIBILITY FOR PAYMENT: I authorize Sensory Connections: Pediatric Occupational Therapy LLC to bill my insurance and receive direct payment from my primary and secondary companies so that Sensory Connections will be paid for the therapy services provided. I understand that I am financially responsible for any fees not paid or covered by my insurance providers. I am responsible for co-pays, co-insurance, and deductibles which are also included as part of my insurance contract. I acknowledge that in consideration of the services provided to me by Sensory Connections: Pediatric Occupational Therapy, LLC, I am financially responsible for the payment of my bill. Please note that refusal to sign this form does not change responsibility for payment in any way.

Signature Parent/Guardian _____ Date _____

Witness Signature:_____ Date _____

Cancellation Policy

Cancellations for scheduled appointments require a 24 hour notice. If 24 hours is not given you will be charged the Late Cancel/No Show fee of $50.00.

Signature Parent/Guardian _____ Date _____

Witness Signature:_____ Date _____

(OVER)

Authorization for Communication with Other Treatment Providers

On behalf of my child, _____ hereinafter referred to as the "Client,"

Client's Name

I authorize and release Samantha Bartley, MS OTR to communicate with other treatment providers (including without limitation, physicians, therapists, and other medical professionals) regarding treatment issues and Client's care.

Signature Parent/Guardian _____ Date _____

Printed Name _____

Relationship to Client _____

List Provider and/or Family Member who OT may communicate with regarding care:

Name:_____ Phone: _____

Address: _____

Name:_____ Phone: _____

Address: _____

Name:_____ Phone: _____

Address: _____

Name:_____ Phone: _____

Address: _____

Name:_____ Phone: _____

Address: _____