PATIENT CONSENT FORM

Client Name: _____ DOB: _____ Insurance #: _____

Responsible Party Last Name: _____ First_____ M.I._____

Responsible Party Address: _____

I hereby grant my permission for the above named client to receive treatment services at OT Solutions Inc. I have received a copy of the Facility Policies and understand the nature of the service that I will receive. By initialing the following items, I acknowledge the policies of OT Solutions Inc. and my responsibilities as stated below:

Release of Medical Records: *I hereby consent to any physician, school, clinic or other health care or related professional in the release of my records pertaining to medical history, services, or treatment, to OT Solutions Inc., if necessary, to be used to gather information for the development of a plan of care and the provision of treatment. I understand that this information will be treated as confidential. I also give consent for OT Solutions Inc. to release information relating to my diagnosis and/or treatment at this facility to my insurance carrier, my physician, my school, or other agencies that I may designate.*

Full Consent -_____ (Initial Here) OR

I hereby give consent to OT Solutions Inc. to release information relating to my diagnosis and/or treatment at OT Solutions Inc. to my physician and my insurance carrier(s). Consent for release of information to other appropriate parties will be designated on an individual basis, via separate written consent, as needed.

Limited Consent- _____ (Initial Here)

HIPAA: *I acknowledge that I have received Notice of Protected Health Information Practices according to the Health Insurance Portability and Accountability Act (HIPPA).*

_____*(Initial Here)*

Consent to Provide Services: *I hereby authorize OT Solutions Inc. to render occupational therapy and/or speech therapy services that have been determined medically necessary by my physician. I understand that such care will be provided by a licensed occupational therapy/speech therapy professional. I have the right to refuse treatment or terminate services at any time by notifying OT Solutions Inc..*

_____ *(Initial Here)*

Financial Responsibility: *I assume full financial responsibility for the services that I will receive at OT Solutions Inc., regardless of third party coverage. I assume full financial responsibility in the event that my health carrier denies insurance payment in part or in full. I understand fees for services are due at the time therapy services are rendered unless other arrangements have been made in advance and that treatment may be suspended until outstanding payments are made. I authorize OT Solutions Inc. to bill my health carrier(s) for services rendered.*

_____ *(Initial Here)*

Cancellations: *I understand that I must notify OT Solutions Inc. at least 24 hours in advance of cancelling a session. I understand that failure to notify OT Solutions Inc. will result in discontinuation of services provided by OT Solutions Inc. as per the missed visit/cancellation policy attached.*

_____ *(Initial Here)*

I certify that all information provided is true and accurate to the best of my knowledge. I, the undersigned, have read and fully understand the contents of this form and hereby agree to authorize the above provisions. I have assumed the responsibility of allowing OT Solutions Inc. to provide occupational therapy/ speech therapy services to the person named and I certify that I am the duly authorized client guardian and can execute the above and accept its terms on behalf of the client.

Responsible Party Signature: _____Initials_____ Date: _____
(Minor's Parent/Legal Guardian)

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