CHILD THERAPY & REHABILITATION LLC
790 FLETCHER DR, UNIT 101
ELGIN, IL 60123-4757

OFFICE: 847-697-7800 FAX: 847-697-7807

PATIENT NAME: _____ **DATE:** _____

PARENT/GUARDIAN: _____

INFORMED CONSENT FOR PHYSICAL/OCCUPATIONAL AND SPEECH THERAPY

I understand the therapy delivered through the utilization of customary and usual techniques has been used to treat various neurological, orthopedic and medical problems. If therapy is ordered for the client by the attending physician or suggested by the therapist and approved by the physician, I desire this service to be performed and have the authority to request such service. I am free to discontinue treatment at any time.

CONSENT FOR RELEASE OF INFORMATION

I hereby give permission for designated health care providers to transmit to Child Therapy and Rehabilitation any medical, therapy or laboratory reports that may be of assistance in the assuring continuation of the above client's health plan. I hear by give permission to Child Therapy and Rehabilitation to release records (including, but not limited to evaluations, treatment records and progress reports) to the client's physician, insurance company, school and or teacher, or the following please specify:

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_____

AUTHORIZATION TO RENDER A EMERGENCY SERVICES TO A MINOR CHILD

I understand Child Therapy and Rehabilitation or its representative will take whatever measures are deemed necessary in the event a medical or other emergency occurs in my absence. I also understand that CTR or its representative will authorize other medical or paramedical personnel to take such actions as may be necessary to perform the standard of care given in similar emergency situations.

ASSIGNMENT OF BENEFITS

FOR AND IN CONSIDERATION of the provisions of therapy services to the above patient, I hereby assign, transfer and set over to Child Therapy and Rehabilitation all of my rights, title and interest in insurance benefits for the services rendered. I hereby authorize payment to be made directly to Child Therapy and Rehabilitation for any charges incurred during the course of treatment; and that verification of benefits does not guarantee payment by the insurance company.

_____ / _____

Signature of Parent/Guardian **Date**