Patient Name_____

Therapy Discipline_____

Guardian/Parent_____

General Consent Form

I, _____ , hereby provide my consent and authorize Therapy Junction to assign *(check all that apply)* **An Occupational Therapist** ☐ **A Speech Therapist** ☐ **A Physical Therapist** ☐ for the purpose of implementing appropriate services, including but not limited to: evaluation, diagnostic testing, and treatment, as deemed medically necessary by their professional judgment. I recognize that there are potential risks associated with therapy treatment, medical treatments and procedures. Furthermore, I understand that the rate of progress cannot be guaranteed.

Therapy Junction is a teaching clinic. In addition to my therapist, I may receive care from therapists in training. They are supervised by licensed care providers. I may decline to have these individuals involved in the plan of care.

Assignment of Benefits

I authorize payment of any and all benefits to Therapy Junction. I understand that I must pay for charges for my care that may not be covered by my health plan or government programs. I also understand that I must communicate any changes in my health plan immediately to Therapy Junction Staff. I must make every effort in getting payment for my care. If I am eligible for payment from more than one type of coverage, Therapy Junction will issue the patient whom signs this document a refund payment. If I have any unpaid charges due to me will be put on my unpaid bill. If there is any money left over as a credit on my account Therapy Junction would then issue a refund.

Release of Information

I consent to and authorize Therapy Junction to use and disclose my health information for *(Check all that apply):*

☐ Treatment

☐ Payment of Services

☐ Healthcare Operation Purposes, including the coordination and quality assessments that Therapy Junction completes. Releases of these may be made to people like your insurance program and/or government programs for the purpose of payment to your account and/or for the purpose(s) of treatment and care coordination within Therapy Junction and its staff.

Patient Name_____

Therapy Discipline_____

Guardian/Parent_____

Patient Rights and Privacy Practices

Therapy Junction supplies all new clients with a Policy Handbook and a Notice of Privacy Practices; these documents give detailed explanations of your rights as a Therapy junction Patient and our privacy practices. By signing this form, you acknowledge that you have received and reviewed a copy of the Policy Handbook and the Notice of Privacy Practices provided by Therapy Junction.

Other Individuals Authorized to Consent to Treatment

In addition to the legal guardians of the patients, the following person(s) **ARE** authorized to consent to recommended medical care for my child. Please give us the name and relationship (grandparent, daycare provider etc.)

Name: Relationship to child:

1._____ _____

2._____ _____

3._____ _____

The Individuals listed below are **NOT** authorized to legally give consent to recommended medical care for my child. If needed, I am aware I may be asked for legal documentation showing this (i.e. An Order for Protection, Legal Custody Paperwork). Therapy Junction Staff will **NOT** correspond with these parties:

Name: Relationship to child:

1._____ _____

2._____ _____

3._____ _____

Signatures

☐ By checking this box, I certify that I understand and agree to the policies and practices of Therapy Junction and give my consent to treat

Print Patient Legal Name_____ Date_____

Signature of Patient or Guardian_____ Print Name _____

Relationship to Patient_____