Sande Rutstein, OTR/L
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Consent to Treatment

Name of Child: _____ Date: _____

Parent(s) / Legal Guardian(s): _____ Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Gender: Male / Female

Insurance: _____

Consent

I, _____, grant permission for New Directions for Kids / Therapy Solutions of the Central Coast to evaluate, and if necessary provide occupational therapy treatment which may require physical contact with the client using various methods, including but not limited to: sensory integration, neurodevelopment treatment, yoga therapy, use of ball exercises, suspended, and other equipment. I understand that I have the right to refuse any proposed treatment modality. I consent for this treatment for (Child's Name): _____

I am aware that I may be present for all sessions, but am not required to stay for the duration of the session. Each individual session will be 60 minutes in length. Parents and Legal Guardians are expected to return 15 minutes prior to the end of the session for consultation and review of the child's progress.

I am aware that I am financially responsible for payment at the end of each therapy session, unless otherwise previously arranged.

I understand that all information (including but not limited to: treatment notes, testing, and assessment information, reports, discussion with pediatricians, teachers, and other care providers) regarding my child is confidential. I agree to the exchange of information from New Directions for Kids / Therapy Solutions of the Central Coast with my child's pediatrician or referring physician and/or my child's school if requested. Occupational Therapy students, student observation, and photographs may only be allowed with my prior consent.

I have read the above and am in agreement with this Consent to Treatment.

Signature: _____ **Date**: _____