



immeasurably more.

## General Patient Information Consent Form

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I \_\_\_\_\_, parent/caregiver/legal guardian of \_\_\_\_\_ hereby authorize Capable Therapy, LLC to evaluate and treat \_\_\_\_\_ for pediatric occupational therapy as prescribed by a physician and/or recommended by occupational therapist.

I also acknowledge that I have read and understand the attached Notice of Patient Information Practices. I understand that the company may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. You have a right to review the Notice of Privacy Practices prior to signing this consent. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company. I also understand that this practice will consider requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Company's Notice of Patient Information Practices. In doing so, I hereby release Capable Therapy, LLC from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

I give consent for Occupational Therapists at Capable Therapy, LLC to leave a message on my voicemail system regarding my child and his/her care. I consent and authorize Capable Therapy, LLC to administer treatment under the direction and supervision of a registered occupational therapist. I understand and am informed that, as in the practice of medicine, occupational therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my child's condition, prior to treatment.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating occupational therapist.

\_\_\_\_\_  
*Patient and Parent/Guardian's Printed Name if*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

*Patient is under 18*

I authorize payment of medical benefits and/or government benefits to Capable Therapy, LLC.

\_\_\_\_\_  
*Patient and Parent/Guardian's Printed Name if*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

*Patient is under 18*