Pediatric POSSIBILITIES, P.A.
"Making it Possible"

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Informed Consent for Occupational Therapy Treatment

I, _____, the parent/legal guardian of _____, hereby request and consent to Pediatric Possibilities, P.A. to evaluate and provide occupational therapy services to my child as prescribed by a physician and/or recommended by a licensed occupational therapist.

I am aware that there is no guaranteed outcome with the proposed course of treatment. I have been given the opportunity to ask questions and all questions have been answered to my satisfaction.

I understand that Pediatric Possibilities, P.A. is dedicated to the future of the Occupational Therapy profession. Due to this dedication, we frequently have students and volunteers within the clinic. Therapist discretion will be used to determine if the student/volunteer shall be included in the therapy session or remain in the observation room.

I understand that my child's protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. For a more complete description of the potential uses and disclosures of the protected health information, please refer to the Notification of Privacy Practices issued on the first day of treatment. If you have misplaced your copy, please contact our office to obtain a new copy.

I understand that attendance is important for my child's progress and for the Occupational Therapist to provide the best intervention for my child and family.

Initial to consent to the following:

_____ I consent to Pediatric Possibilities, P.A. to leave voicemails and/or emails regarding my child's care.
_____ I consent to receive text and/or email message reminders (plan text messaging fees apply).
_____ I consent to Pediatric Possibilities, P.A. to provide first aid to my child, should it be deemed necessary.
_____ I consent to Pediatric Possibilities, P.A. to communicate with my referring physician and/or primary physician to obtain a Physician's Order and medical information for treatment if needed.
_____ I consent to Pediatric Possibilities, P.A. discussing the care of my child with the following additional care providers (grandparents, nannies, etc..)

_____
_____

I consent to Pediatric Possibilities, P.A. to provide occupational therapy services under the direction and supervision of a licensed Occupational Therapist. You have the right to revoke this consent, in writing, at any time.

_____ _____
Client Signature (Parent or Guardian if Client is a minor) Date

_____ _____
Print Parent or Guardian Name Client's Name

edited 01.01.2025