PEDIATRIC THERAPY SERVICES | where children learn and leap

Consent and Attendance

Patient Name:_____Birthdate:_____

Attendance Policy

Welcome to Pediatric Therapy Services, Inc. (PTS)

Beginning in a therapy program is a big step and a real commitment. Our entire staff is committed to providing you and your family with the professional services and timely information that you will need in order to progress in your therapy goals. We also need your commitment of consistent attendance and diligent effort to make our partnership a success.

If you must cancel a therapy session, we ask that you call us as far in advance as possible.

We feel strongly that consistent attendance is important to the success of your therapy program. We have developed specific procedures to clarify our expectation of your attendance. We ask you to follow the procedures listed below.

I understand and agree to the following related to attendance of my therapy sessions

- I understand that consistent attendance of scheduled therapy sessions is critical to improvement and progress.
- I believe that attending therapy sessions is a commitment I am ready to make.
- I understand that if the commitment becomes difficult for me to meet I will discuss it with the front office and we can work toward a solution
- I will notify PTS of planned absences or vacations in advance.
- I will phone PTS before my appointment time if I am unable to attend my therapy session. If I do not call, my absence will be considered a "no show."
- If I "no show" for a scheduled appointment, I will not be placed on the schedule again until PTS receives a phone call requesting an appointment.

Printed Name:_____Relationship to patient:_____

Signature:_____Date:_____

OBSERVATION/ASSISTING PERMISSION

PTS participates with local colleges, universities and interested volunteers in allowing observation and assisting experiences within therapy sessions. This community service allows interested persons to gain information about the various disciplines and professional roles and responsibilities. These individuals are counseled prior to their observation and/or therapy assisting

activities regarding confidentiality of patient information, and agree to abide by PTS policies on confidentiality as part of their observation and assisting experience.

Please check:

☐ **I do**
☐ **I do not**
give permission for observations and/or assisting of supervised therapy sessions.

Printed Name:_____Relationship to patient_____

Signature:_____ Date:_____

PHOTO/MARKETING RELEASE

☐ **I do**
☐ **I do not**
give my permission to PTS to take picture(s) and/or video of my child.

Picture/videos may be used for HEP, display, education, website and/or marketing.

Printed Name:_____Relationship to patient_____

Signature:_____ Date:_____

CONSENT FOR MEDICAL TREATMENT/THERAPY TREATMENT

I give permission to PTS staff to: provide therapy services and or administer medical aid or to seek and have aid provided from a qualified medical professional if the situation requires same.

Printed Name:_____Relationship to patient_____

Signature:_____ Date:_____

Phone#_____Phone#2_____

Primary Care Physician:_____Phone#:_____

This entire consent is valid from date of my signature until closure of patient file or until I revoke it in writing.