Company logo here

Occupational Therapy Services
"[Practitioner/clinic name]", OT
Reg # (if solo owner)

Consent and Payment Agreement

I, _____ (Parent/Guardian name) confirm that _____(Child's name) was born _____ and agree to the following on _____:
Month/ Day/ Year Date

1. I consent to my child receiving Occupational Therapy services from "[Practitioner/clinic name]" and I will participate to my capability along with my child in the therapy services provided.

2. I consent to my child receiving Occupational Therapy services through telehealth (phone and/or video) if required when in-person session are not available and services can be realistically carried out via telehealth means.

3. I will disclose any medical reason why my child's participation in these services might be limited.

4. I will work collaboratively with the therapist to address behavioural issues that affect the outcome of therapy sessions. If required and/or if behavioural services are involved there will be a behaviour plan that is adhered to.

5. I agree to have myself and/or my child's picture/video taken. Any pictures/videos taken are for the sole purpose of assessment and will only be used for assessment and/or treatment for services provided. Unless permission is otherwise granted.

6. I consent to the collection and use of my and/or my child's personal health information. I understand that all shared private information will be kept with strict confidence and will not be released without my voluntary and written consent. I understand and agree to the use of Therabyte App cloud-based services, including Teleheath and the Client Portal to gather and share personal information of me or my child. I understand that I can review Therabyte App's Terms of Service and Privacy Policy at their website https://therabyte.app. Therabyte App is not For clarity, Therabyte is not a healthcare provider and does not provide medical care or advice. They only ensures the handling of personal information including collection, storage, and destruction of information is done in accordance with the applicable health professional's regulating bodies and the federal and provincial privacy laws.

7. I acknowledge and agree that telehealth and conferencing technology comes with inherent risks of privacy security and that while all reasonable measures are taken to secure my personal health information, no technology interface is fully secure.

8. "[Practitioner/clinic name]" is permitted to release and obtain information from the following professionals involved in my child's rehabilitation journey. This authorization is in effect until therapy sessions are concluded or otherwise stated in writing. E.g. Past OT, SLP, BC, Teacher, Daycare worker, Family Doctor

Initial for consent given	Professional Type:	Name:	Number:

9. OT services are billed at a rate of $1xx/hr for the session. Session billing is an inclusive fee for the time associated with the session to prepare, document, and communication between sessions.

10. Additional Travel fee: for home visit is $xx

11. Additional time is billed at $1xx/hour for agreed upon services. This may include: equipment sourcing, completion of a justification for equipment, team and phone meetings, planned phone call appointments including parent support, written assessment and progress reports, and material preparation requested specifically for your child.

12. Missed appointments or cancellations.
    a. _____ I understand that I will be billed when a cancellation occurs within 24 hours of the scheduled appointment time. (I understand that "provider name" will do their best to use this time to work on my child's file.)

13. Payment.
    a. _____ If a **third party** is paying for therapy services, I agree to facilitate that payment be made directly to the therapist. (eg. AFU, AHP)
    b. _____ I understand that should the third party not reimburse the full cost of the therapy services, I remain responsible for those costs.
    c. _____ **Private pay services**, I agree to pay within 2 weeks of receipt of monthly invoice via e-transfer, cash or cheque. (Payable via etransfer to youremail@outlook.com).

____I have read, understood and agree to the above terms as evidenced by my signature.
____I understand that I have the right to withdraw this consent at any time, without affecting my right to future care, by providing such withdrawal of consent in writing by email or other written means.

Signature: _____ Date: _____

Name: _____

Relationship to patient, if signed by representative of patient: _____

Witness: _____ Date: _____