Company Logo here

Your company/practice/clinic name here
Consent Form

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

1. [Company Inc./Practitioner] is permitted to release and obtain information from the following medical professional involved in my child's assessment or treatment/rehabilitation.

Professional Type:	Name:	Number:

2. I will participate in the therapy sessions and disclose any medical reason why my child's participation in the program might be limited. I will work collaboratively with the therapist to address behavioural issues that affect the outcome of therapy sessions.

3. I agree to have my and/or my child's picture/video taken. Any pictures/videos taken are for the sole purpose of the testing and will only be used for assessment or treatment/rehabilitation.

4. I agree to accept the participation of [Company Inc.] therapist/consultant trainees and/or therapist/consultant supervisors in all settings that they are allowed when requested in order to ensure quality services are delivered to our clients.

5. I agree to receive services for my child through telehealth (phone and/or video) if required due to COVID-19 and the same does not compromise the delivery of my rehabilitation program.

6. I acknowledge and agree that digital collection of data as well as, telehealth 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.

Missed or Cancelled Appointments
Please note that it is our policy that all cancellations of appointments need to be made with more than 24hrs notice. You will be billed for any missed or cancelled appointments with less than 24hrs notice. Also note that most insurance providers/funders will not pay or reimburse you for these missed appointments.

____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: _____