CONSENT FOR THERAPY SERVICES

I hereby authorize Jane L. Spickelmier, PT or Nicole A. Sanguino PT, DPT and associates to provide the prescribed therapy service

to: _____

(Child's Name Above)

I understand that the therapy provided to my child by the therapist is intended to assess my child's needs and improve my child's functional abilities.

The general benefits and contraindications of therapy treatment procedures have been explained to me to my full understanding. I am aware that a therapist does not diagnose illnesses or disease and does not prescribe medications.

I have informed the therapist of all my child's physical conditions, medical conditions and medications, and will keep the therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

Your child's special needs including allergies and medical contraindications can be listed below.

_____

I fully understand the course and plan of assessment and treatment for my child and agree to allow my child to be evaluated and to participate in such outlined activities. Therapy services may include initial evaluation, treatment, consultation, collaboration and periodic re-evaluations to assess the need for implementation or modification of treatment.

Parent/Guardian Signature Date

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