Fundamental Therapies

Consent to Treat

Patient Name:

Consent to Treatment and Authorization for Release of Information:	
I hereby authorize Fundamental Therapies and its staff to evaluate and treat the above-named patient as prescribed by my physician and recommended by the therapist. I understand that I have the right to remain present during all therapy sessions and ask any questions I may have of the therapy program. I authorize Fundamental Therapies to request appropriate information from my child's physicians. I further authorize Fundamental Therapies to release any pertinent information to these physicians. I have read and understand the above consent.	
Parent/Guardian Signature_____ Printed Name: _____ Relationship to child: _____	Date:

Acknowledgment of Risk	
I acknowledge that there is some risk inherent in the use of the therapy equipment at this clinic and agree to indemnify and hold Fundamental Therapies harmless from any and all losses and claims for any injuries or other damages occurring to myself, my child(ren) or our belongings from the use of therapeutic equipment.	
Parent/Guardian Signature_____ Printed Name: _____ Relationship to child: _____	Date:

Patient Supplemental Informed Consent

As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal precautions and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your local grocery store or in the community. "Social Distancing" nationwide has reduced the transmission of the coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, therapist and sometimes other patients at all times.

Please check ☐ YES or ☐ NO if you would like your therapist to wear a mask during your child's treatment session. Can discuss safety further upon meeting your child's therapist during the initial evaluation.

I hereby authorize Fundamental Therapies and its staff to evaluate and treat the above-named patient as prescribed by my physician and recommended by the therapist. I understand that I have

the right to remain present during all therapy sessions and ask any questions I may have of the therapy program. I authorize Fundamental Therapies to request appropriate information from my child's physicians. I further authorize Fundamental Therapies to release any pertinent information to these physicians. I have read and understand the above consent.

Parent/Guardian Signature_____ Printed Name: _____ Relationship to child: _____	Date:

Telehealth Consent to Treatment and Authorization for Release of Information
I hereby authorize Fundamental Therapies and its staff to provide the above-named patient therapy as prescribed by my physician and recommended by the therapist, through the method of telehealth/telemedicine. I understand that I am obligated to remain present during all sessions and ask any questions I may have of the therapy program. I authorize Fundamental Therapies to request appropriate information from my child's physicians. I further authorize Fundamental Therapies to release any pertinent information to these physicians. I authorize payment directly to Fundamental Therapies and its employees for telehealth services provided to my child. This is a direct assignment of my rights and benefits under my insurance policy. I hereby give permission for my child to be on video and potentially recorded during the telehealth sessions. To maintain HIPPAA privacy, it is best that our patients do not receive services in a public setting. If that is necessary, the therapists will do their best to implement reasonable HIPPA safeguards- such as but not limited to- using lowered voices, not using a speakerphone, or recommending that the patient moves to a reasonable distance from others when protected health information (PHI) is being discussed. This will aim to limit incidental uses or disclosures of PHI.

Parent/Guardian Signature_____ Printed Name: _____ Relationship to child: _____	Date:

Notice of Privacy Practices (HIPPA Acknowledgement / Consent)
I hereby acknowledge that I can print off a copy of Fundamental Therapies Privacy Practices from the website. In addition, I hereby consent to the use and disclosure of mine and my child's personal health information for the purposes of treatment, payment, and health care operations.

Parent/Guardian Signature_____ Printed Name: _____ Relationship to child: _____	Date:

Fundamental Therapies

Assignment of Benefits	
I hereby authorize payment directly to Fundamental Therapies and its employees for therapy services provided to my child. This is a direct assignment of my rights and benefits under my insurance policy. A photocopy of this assignment shall be considered as effective and valid as the original	
Parent/Guardian Signature_____ Printed Name: _____ Relationship to child: _____	Date: