In Harmony Pediatric Therapy

CONSENT TO TREAT

I, ______________________________ consent for In Harmony Pediatric Therapy to provide my child, ______________________________________ with Occupational, Physical, Speech Therapy, and/or Music Therapy services. I consent to care and treatment falling under the practice guideline of the American Occupational Therapy Association (AOTA), American Speech-Language-Hearing Association (ASHA), American Physical Therapy Association (APTA), American Music Therapy Association (AMTA), and the State of Georgia. I acknowledge that there is always a risk of injury with any therapy involving physical activities.

___________________________ ______________________
Parent/Legal Guardian Date

PERMISSION FOR EXCHANGE OF INFORMATION

I authorize In Harmony Pediatric Therapy to release necessary and pertinent medical information to physicians, case managers, and insurance companies as needed for my child, ____________________________.

Approved information may be exchanged with the following people *directly* related to my child's care:

- ☐ Other Therapists
- ☐ School Name: _______________________________________
- ☐ Please list any other/s

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Approved information includes **written documents** and/or **verbal discussion.**

____
PARENT/GUARDIAN SIGNATURE DATE

____
PRINTED NAME

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