Kids First Therapy

CONSENT AND AUTHORIZATION TO TREAT

I,_____, hereby give my permission to Kids First Therapy, LLC to provide Physical Therapy/Occupational Therapy/Speech Therapy and/or CBRS services to _____. Kids First Therapy, LLC has my permission to do a formal evaluation and provide treatment. I give my permission to Kids First Therapy, LLC to bill Medicaid or a Third Party Insurance Company and to have that money assigned to Kids First Therapy, LLC. I give my permission for Kids First Therapy, LLC to release information to any professional group or agency that will help in obtaining funding for Physical Therapy/Occupational Therapy/Speech Therapy and/or CBRS services.

_____ _____ _____

Parent/Guardian Signature Date Relationship to Patient

CONSENT AND AUTHORIZATION TO EXCHANGE INFORMATION

Please list all Agencies/Facilities Exchanging Information with Kids First Therapy, LLC.

CDSA _____ _____

All IFSP providers _____ _____

Physician _____ _____

I,_____, authorize the above named facilities/agencies to exchange information concerning the above named patient. This information shall include observation of the child in daycare or school, interviews with teachers, counselors, directors/principals, psychological data, any medical or psychiatric data, testing results, and reports. This data will be exchanged for diagnostic/therapeutic purposes. I understand that I may revoke this consent at any time, except to the extent that action based on this consent has already been taken. This authorization is fully understood and is made voluntarily on my part.

_____ _____ _____

Parent/Guardian Signature Date Relationship to Patient

_____ _____

Witness Signature Date

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