Thera P E D S

Phone: 501-258-1983
Fax: 501-847-377-9900

# Parent Consent

Your child has been referred for a formal therapy evaluation. If standardized testing indicates need for therapy services, we would highly recommend these services for your child.

**** Please complete this form at your earliest convenience and return to TheraPEDS.***

Child's Name: _____ Child's Date of Birth: _____

School and/or facility your child attends: _____

**Contact Information**

Parent's Names: _____ and _____

Address: _____

_____

Phone Number: Primary #_____ Name _____

Secondary #_____ Name_____

Email Address: _____

**Please provide accurate information so that we can contact you with the results of your child's evaluation*

**Billing Information**

☐ My Child has Medicaid

Medicaid Number: _____ Social Security Number _____

Name of Primary Care Physician: _____ Phone: _____

☐ My Child has Health Insurance Coverage *MUST ATTACH A FRONT AND BACK COPY OF INSURANCE CARE

Name of Primary Care Physician: _____ Phone: _____

By signing this Consent Form, I authorize TheraPEDS PLLC to conduct a formal therapy evaluation as well as treatment if deemed necessary according to the testing results as well as from your primary care physician. Further, I authorize the release of any medical or other information necessary to process claims associated with services provided to my child by TheraPEDS. I also authorize payment of benefits to TheraPEDS. I understand that giving consent for the above recommendations is not required and can be canceled anytime.

_____ _____

Parent/Legal Guardian's Signature Date