CONSENT FORM

TheraTeam Clinic
22461 I-30 Suite 301
Bryant, Arkansas 72022
Phone: 501-847-2555
Fax: 501-847-2250

☐ Speech Therapy ☐ Occupational Therapy

☐ Physical Therapy

Your child has been referred for a formal evaluation in the area(s) marked above. TheraTeam Speech-Language Pathologist, Occupational Therapist and Physical Therapist feel your child would benefit from therapy services should testing results indicate the need. These services may address a range of skills including but not limited to: articulation (speech), expressive/receptive language, social skills and behavior, fine motor, gross motor, sensory integration, eye-hand coordination, activities of daily living, basic concepts and kindergarten readiness skills, etc.

Please complete this form at your earliest convenience and Return to TheraTeam or Daycare Director.

Child's Name: _____ Child's Date of Birth: _____
First Middle Last

Facility Your Child Attends (daycare/pre-school/etc.): _____

Referral Details: _____

Contact Information

Parents' Names: _____ and _____

Address: _____
Street Apt. #

_____
City, State Zip Code

Phone Number(s): Primary #: _____ - Name: _____

Secondary #: _____ - Name: _____

** Please provide accurate information so we can contact you with the results of your child's evaluation and/or request further information to appropriately care for your child's needs.*

Email Address: _____

Preferred Method of Communication (circle one): Primary Phone # ☐ Secondary Phone # ☐ Email Address ☐

Billing Information

Please Check the Appropriate Choice(s) from the Following:

☐ My Child has Medicaid, ARKids or TEFRA Coverage:

Medicaid Number: _____ Social Security Number: _____

Name of Primary Care Physician: _____

Phone # of Primary Care Physician: _____

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

Name of Primary Care Physician: _____

Phone # of Primary Care Physician: _____

☐ My Child does not have Medicaid, ARKids, TEFRA or any other insurance coverage. *PLEASE CALL FOR ASSISTANCE

By signing this Consent Form, I authorize TheraTeam Rehab Services, Inc. ("TheraTeam") to conduct a Speech-Language, Occupational, and/or Physical Evaluation and/or HRS Consultants to conduct Developmental Evaluation as well as treatment if deemed necessary according to testing results and your child's 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 TheraTeam and/or HRS Consultants. I also authorize payment of benefits to TheraTeam and/or HRS Consultants. Signature further ensures that a copy of TheraTeam's Privacy Policy has been received and reviewed. I understand that giving consent for the above-mentioned purposes is voluntary and can be revoked at any time.

_____ _____

Parent/Legal Guardian's Signature Date