



Consent for Evaluation and Treatment

Client Information

Child's Name: _____ Date of Birth: _____
Parent/Guardian Name: _____
Relationship to Child: _____
Phone Number: _____ Email Address: _____

Purpose of Evaluation and Treatment

Your child has been referred for occupational therapy services to support their participation in everyday activities such as play, self-care, emotional regulation, and school-related tasks. The initial evaluation may include observations, parent interviews, standardized and non-standardized assessments, and interaction with your child.

If therapy is recommended, treatment will be tailored to your child's unique needs and goals. Sessions may involve movement, play-based tasks, sensory activities, fine motor practice, and home recommendations.

Consent for Services

I understand and agree to the following:

- I give permission for my child to participate in an occupational therapy evaluation and, if indicated, in ongoing treatment services provided by Hand in Hand Therapy.
- I understand that therapy services will be provided in a safe, supportive environment and are based on best practices in pediatric care.
- I understand that I can ask questions at any time and that I may withdraw consent at any time.

Benefits and Risks

Occupational therapy may improve my child's independence, emotional regulation, coordination, strength, attention, and daily function. I understand that while benefits are expected, they are



not guaranteed. Some therapy activities may be physically or emotionally challenging. My child will be supported at all times, and their well-being is a priority.

Confidentiality & Privacy

Hand in Hand Therapy complies with all HIPAA privacy regulations. Information shared during therapy will be kept confidential and only shared with others (e.g., physicians, teachers) with written permission. I have the right to access my child's therapy records upon request.

Parent/Guardian Responsibilities

- I will participate in communication and collaboration as needed.
- I understand the importance of regular attendance.
- I agree to follow any home strategies as recommended.
- I understand the clinic's cancellation and financial policies (provided separately).

In the event that in-person services are not possible or are supplemented with virtual services, I give my consent for my child to receive occupational therapy via secure telehealth platforms. I understand:

- Telehealth may include video conferencing, phone communication, or digital resources.
- All efforts will be made to protect privacy and confidentiality, but there are inherent risks with online communication.
- I may stop or decline telehealth services at any time.

Initial here if you consent to telehealth services: _____

Consent Acknowledgement and Signature

I have read and understand the information above. I give consent for Hand in Hand Therapy to evaluate and treat my child. I understand I can revoke this consent at any time in writing.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____