HAND IN HAND THERAPY

Guiding little hands. Growing big skills.

# 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, PLLC.
- 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.

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## Confidentiality & Privacy

Hand in Hand Therapy, PLLC 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, PLLC to evaluate and treat my child. I understand I can revoke this consent at any time in writing.

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

**Printed Name: _____**