
# Release of Information and Consent for Treatment

Patient Name: _____ Date of Birth: _____

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment from FUNctional Play Therapy. I permit therapist caring for me to treat me in ways they judge are beneficial to me. I consent to rehabilitation and related services. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to FUNctional Play Therapy to release information, verbal and written, continued in mu medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize FUNctional Play Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relations to my treatment.

The signature below certifies that I have read and understand the above information

Initial: _____

**Notice of Privacy Practices (HIPPA acknowledgement/Consent)**

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for FUNctional Play Therapy.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operation.

Initial: _____

**Payment Private Pay Model**

I hereby acknowledge that I am responsible for the payment at beginning of each visit if choosing the private pay model. I acknowledge that the fee is $50 for a half an hour and $100 for an hour.  I acknowledge that each evaluation and re-evaluation regardless of time is $100.

Initial: _____

I herby acknowledge that the information I provided on the Intake form is correct.

_____ _____

Patient/Guardian Signature Date