One of a Kind
THERAPY ™
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Oneofakindtherapy@gmail.com
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Consent and Authorization

Child's Name: _____

1. I hereby consent to and acknowledge receipt of One of a Kind Therapy's HIPAA Notice and Payment Policies. I consent that my protected health information be used to provide and coordinate treatment, to obtain payment, and for business operations. I understand that the above documents provided by One of a Kind Therapy explain my rights to privacy regarding my protected health information and provide specific information and a complete description of how my health information may be used and disclosed.
2. I authorize One of a Kind Therapy to render appropriate therapy services to the above named patient. I understand that care will be provided by an appropriately trained health care professional. I recognize and agree that I have the right to refuse treatment or terminate services at any time by notifying the One of a Kind Therapy, office in writing. In addition, One of a Kind Therapy may terminate services by notifying me of termination. I hereby authorize One of a Kind Therapy to bill my insurer identified as providing coverage for the insured and allow for the release of any information necessary to process claims for medical benefits.
3. I consent and agree that One of a Kind Therapy and its staff may contact me, leave voice messages, send me text/video messages and/or send me emails to the phone number(s) and email address(es) I have provided them. I understand that these messages can include protected health information, such as patient name, information that identifies the practice as a speech/occupational/physical therapy practice, and any pertinent clinical/therapy information. I understand that text messages and emails are not secure forms of communication.

I have read and fully understand the content of this consent and authorization release and hereby agree to and authorize the foregoing provisions. As used in this document, the terms "I", "me" and "my" refer to and include, in addition to the undersigned, the patient named above and other for whom the undersigned is responsible or for whom the undersigned has assumed responsibility engaging One of a Kind Therapy to provide services to the patient. This authorization will EXPIRE upon my discharge from patient services or upon my written request to deny future releases.

Signature:_____

Printed Name:_____

Date :_____