PEDIATRIC OCCUPATIONAL THERAPIST
SAN FRANCISCO, CA

Consent for Treatment

Child's Name: DOB:

Parents:

Address:

Telephone: (day) (eve)

Email:

Referred By:

Emergency Contact

Name: Relationship to Child:

Telephone:

Allergy Alert / Dietary Restrictions

I, *(please print name)* ,

hereby assert that the above named child has the following allergies and/or food restrictions:

CONSENT FOR TREATMENT and RELEASE & EXCHANGE OF INFORMATION

I authorize and direct Allison Atwood to perform appropriate assessment and treatment procedures upon the above named child. I further authorize and direct Allison Atwood, having assessed and/or treated the above named child to release any appropriate information acquired in the course of the assessment and treatment to the following agencies, facilities, schools, or related professionals:

School:

Medical Doctor:

Psychologist/Educational Therapist:

Speech Therapist/Physical Therapist:

Other:

Insurance & Policy Number (only if you plan to seek reimbursement):

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OCCUPATIONAL
THERAPIST
SAN FRANCISCO, CA

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PAYMENT AGREEMENT

I have read and understand the attached letter stating policies of practice, including the cancellation policy. A cancellation after 8:00 AM the day of treatment will be charged at the full treatment rate. If your treatment time is before 10:00 AM, please call by 5:00 PM the previous business day to avoid being charged.

I agree to pay Allison Atwood the full amount of any and all fees related to services rendered. Payment is expected at the time of service.

I understand that if I am seeking reimbursement from my health insurance company, I must file a claim for benefits independently.

FEES ARE AS FOLLOWS:

Assessment & report:	$950
Assessment w/school visit & report:	$1200
Treatment:	$170/session (50 minutes)
Treatment Plan:	$350 (includes review of records, written goals, and a parent meeting)
Consultation (one time appointment):	$225/session (60 minutes)
Reports & Home programs:	$170/hour
Travel time:	$170/hour (billed in 15 minute increments)

Responsible Party Signature:

Name (print): **Relationship to child:**