Physical and Academic Learning Services, PLLC

P.A.L.S.

1370 Frelsburg Rd, Alletyon TX 78935
Phone: 979-733-4870, Fax: 979-732-6465
palsotclinic@yahoo.com

Consent Authorization Form

Client Name:_____DOB:_____

CONSENT FOR TREATMENT:

I hereby voluntarily consent to such medical care treatment, including any diagnostic procedures and tests to be performed on the patient named herein that the patient's physician, his or her associates, assistants and other health care providers believe are necessary for the care of the patient. I hereby state that I have the legal right to the medical treatment of the patient listed herein. In the course of treatment, I understand and acknowledge that no warrant or guaranty will be made as a result of treatment.

PERMISSION TO PHOTGRAPH AND VIDEO:

I authorize P.A.L.S. to photograph/video my child. I give my consent to allow P.A.L.S to display the photographs in their office and to be in the public view. Videos can be used for educational, record keeping or promotional use. These photos/videos will not be purchased and/or duplicated by any other source.

CONSENT FOR ANIMAL-ASSISTED THERAPY:

My child may participate in the animal-assisted therapy program. I am aware that although highly unlikely, there are always potential risks with exposure to any animal. Under Texas Law (Chapter 87, Civil Practice & Remedies code), and Equine Professional is not liable for an injury to or the death of a participant in equine activities resulting from inherent risk of equine activities. I hereby agree to hold harmless and indemnify P.A.L.S and further release them form any liability or responsibility for accident damages, injury, or illness to all types of animals on the P.A.L.S. property.

CONSENT TO RELEASE INFORMATION BETWEEN PROFESSIONALS:

When necessary, therapist will communicate with teachers, and other educational professionals to maximize learning environment; as well as other medical professionals to maximize Plan of Care. By signing below you are providing consent to P.A.L.S to request or disclose PHI about clients to a third party as deemed medically necessary.

EMERGENCY MEDICAL RELEASE:

In the vent of my absence or inability to provide consent, I hereby give my permission for P.A.L.S. to seek the appropriate emergency medical attention for my child.

PICK UP RELEASE:

P.A.L.S requests that the responsible party that brings the client to the facility remains on site during the therapy session; however, if a patient must be dropped off P.A.L.S. will not release a client/minor to anyone other than their parent unless express permission is given. If you know of anyone who may bring or pick up the client/minor please notify the therapist in advance.

TEACHING AND RESEARCH ACTIVITIES:

I give my permission for occupational therapy student or P.A.L.S. Staff to observe my child's therapy.

DATE: _____SIGNATURE: _____