WAUWATOSA THERAPIES, LLC
PEDIATRIC THERAPY SPECIALISTS

Consent to Treat

[Occupational Therapy]

Client Name: _____ DOB:_____
Emergency Contact Name / #: _____

I. Consent to Evaluation

I hereby consent to the evaluation of my child's condition by a licensed occupational therapist employed by Wauwatosa Therapies.

II. Consent to Treatment

I hereby consent to the treatment of my child's condition by a licensed occupational therapist which can include one or more of the following interventions:

*Therapeutic Exercise
*Social Skills Training
*Splinting / Orthotics
*Vestibular-Re-education / Balance Training
*Manual Therapy (soft tissue mobilization / massage)
*Sensory Integration
*Self-Regulation
*Neuro-Developmental Treatment
*Aquatic Therapy
* Fine/Gross Motor Coordination
*Therapeutic Listening (electronically modulated auditory intervention)
*Oculo-motor / Oral-Motor Coordination

III. Patient Responsibility

-It is the patient's responsibility to inform Wauwatosa Therapies of all medical conditions, outside treatments, and medications at the initial evaluation.
-It is the patient's responsibility to inform Wauwatosa Therapies of any change in medical condition or insurance status (including change of company and / or termination of policy, etc).

Date Signed: _____

_____
Father, Mother or Legal Guardian (Print Please)

_____
Father, Mother or Legal Guardian (Signature)