



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 | *Sensory Integration |
| *Social Skills Training | *Self-Regulation |
| *Splinting / Orthotics | *Neuro-Developmental Treatment |
| *Vestibular-Re-education / Balance Training | *Aquatic Therapy |
| *Manual Therapy (soft tissue mobilization / massage) | *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)