

Capable Kids of the North Shore, LLC
85 Revere Drive, Suite G
Northbrook, IL 60062
Ph. 847.498.2003 Fax 847.498.2013

Permissions, Consents, and Responsibilities

Patient Name: _____

Consent to Treat: I hereby authorize and consent to treatment by any of the following independent providers at Capable Kids of the North Shore, LLC :for my child: Vicki Abrams, OTR/L; Karla F. Davis, MA, CCC-SLP; Jan Marsden Johnson, PhD, CCC-SLP and associates; Bridget Kleiderer, PT; Sheila Poteshman, OTR/L. I understand that no guarantee has been made as to the results of the therapy given to my child. This consent shall remain in effect until I choose to revoke it in writing or unless mutually agreed upon by the therapist and parent/guardian.

Release of Information and Assignment of Benefits: I understand that I am responsible for any fees for service rendered for my child. I hereby authorize (specific independent provider's names) _____ to release any medical information to my insurance carrier concerning all conditions/diagnoses in order to process any claims on my child's behalf. I hereby assign to (specific independent provider's names) _____ payments made by my insurance carrier.

Authorization to Discuss My Child: I hereby authorize the independent provider at Capable Kids to discuss appointment information and relevant therapy information with the following named person(s): _____

Commitment to Your Care: I understand that in order to have an effective therapist-patient and parent relationship. It is my responsibility to be compliant with the independent provider's treatment recommendations and office policies. I understand that I may terminate this relationship at any time and request my child's records be transferred to another provider.

Privacy Notice: I hereby give my consent to the independent provider at Capable Kids to use and disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my child's record. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the relevant independent provider. I also understand that I will not be able to revoke this consent in cases where the independent provider has already relied on it to use or disclose my health information. I acknowledge that I have been given the opportunity to receive or review the Privacy Practices notice of the independent provider at Capable Kids of the North Shore, LLC or have received it on a prior visit.

Parent or Guardian

Date