



# Today's Therapy Solutions

5500 N. Western, #153  
Oklahoma City, OK 73118  
405.735.6388

## Consent for Evaluation and/or Treatment

I consent to the evaluation and/or treatment of \_\_\_\_\_ at Today's Therapy Solutions (TTS) and authorize the qualified personnel thereof to perform such diagnostic procedures and administer such care and treatments as may be directed by the clinic policy or ordered and/or prescribed by the clinical staff person who is responsible for my child's care.

I acknowledge that I have been fully informed of evaluation procedures, care and treatment of my child, and any risks associated with it have been addressed to my satisfaction. I understand that I may be asked to participate in my child's therapy/evaluation.

I understand that the professionals and staff of TTS are required by Oklahoma law to report reasonable suspicions of child maltreatment. I understand that if I or my child is in danger of hurting ourselves or others, this information may be reported in order to obtain appropriate protection. I understand that professionals and staff of TTS will keep records and information regarding my child's treatment confidential, except as authorized by me, as required by law, or as needed to protect persons from harm and to respond to reasonable suspicions that harm has occurred. I understand that TTS professionals and staff may share information among themselves for the purposes of coordinating care and for other purposes necessary to carry out regular clinic operations. I understand that the information shared will be the minimum necessary to carry out these activities.

I give permission for the person who brings my child for an evaluation and/or treatment to provide and to receive information concerning him/her.

I understand and agree that the professionals and staff of TTS, when services are billed to a 3<sup>rd</sup> party insurance provider, will contact and provide information to my insurance carrier in order to obtain payment for evaluation and/or treatment, and to document my child's evaluation results, treatment plan (if any), and diagnosis (as required by applicable contracts). I understand that payment or co-payment, if applicable, is due at the time of service, unless other arrangements have been made in advance.

The information in this consent form has been discussed with me. I have been given the opportunity to ask any questions I have regarding this consent. I am legally authorized to consent to the services provided by TTS for the above-named child patient.

\_\_\_\_\_  
Patient DOB

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Patient SSN

\_\_\_\_\_  
Parent or Guardian Name

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Today's Date