TOTAL Kids
PEDIATRIC THERAPY
Phone: 870-701-0273
Fax: 870-701-0110

Parent Consent

Childs Name: _____ Childs Date of Birth: _____

School and/or facility your child attends: _____

Contact Information

Parent's Names: _____

Address: _____

_____

Phone Number: Primary# _____ Name _____

Secondary# _____ Name _____

Email Address: _____

**Please provide accurate information so that we can contact you with the results of your child's evaluation*

PLEASE SELECT WHICH AREA OF CONCERN YOU WANT YOUR CHILD TO BE EVALUATED FOR:

☐ PT	☐ OT	☐ ST

Billing Information

- ☐ My Child has Medicaid
  - Medicaid Number: _____ Social Security Number _____
  - Name of Primary Care Physician: _____ Phone: _____
- ☐ My Child has Private Health Insurance Coverage
  - ***MUST ATTACH A FRONT AND BACK COPY OF INSURANCE CARD***
  - Name of Primary Care Physician: _____ Phone: _____

By signing this Consent Form, I authorize Total Kids Pediatric Therapy to conduct a formal therapy evaluation as well as treatment if deemed necessary according to the testing results as well as from your primary care physician. Further, I authorize the release of any medical or other information necessary to process claims associated with services provided to my child by Total Kids Pediatric Therapy. I also authorize payment of benefits to Total Kids Pediatric Therapy. I understand that giving consent for the above recommendations is not required and can be canceled at any time.

_____ _____

Parent/Legal Guardian's Signature Date