CONSENT TO TREAT

The patient, or patient's legally authorized representative if a minor, authorizes the therapist(s) at Live Oak Children's Therapy to examine and treat the patient's condition(s). The patient authorizes the therapist(s) to perform procedures as deemed appropriate to improve the patient's condition.

It is the patient's responsibility to inform the therapist(s) about any health problems or allergies he or she has. It is also the patient's responsibility to inform the therapist(s) about drugs or medications he or she is taking. The patient will not hold the therapist(s) responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The patient understands that the practice of physical, occupational, and/or speech-language therapy (collectively "therapy services") is not an exact science and that no guarantees or promises have been made to him or her as a result of treatments or examinations by the therapist(s). The patient understands that no contract, warranty, guarantee, or promise concerning the results of the therapy services is made. The patient intends to waive liability for such treatment with the exception of acts of negligence.

The patient has the right to informed participation in decisions involving his or her health care. The patient shall not participate in any procedure(s) without his or her voluntary, competent, and understanding consent or the consent of the patient's legally authorized representative. The patient has the right to a full explanation of any treatment or procedure utilized. The patient has the right to refuse treatment, but, in doing so, the patient understands that the outcome of the treatment may be affected.

The patient, or patient's legally authorized representative, hereby consents to such treatment by authorized personnel of Fruin & Associates, Inc. dba Live Oak Children's Therapy, as may be dictated by prudent medical practice for patient's illness, injury, or condition, beginning on this date and terminating when notification is given to Fruin & Associates, Inc. dba Live Oak Children's Therapy in writing.

_____ _____

Patient or Legally Authorized Representative Date

_____ _____

Witness Date

Live Oak Children's Therapy

Let's Stay in Touch!

We want to be sure we can reach you. Please provide the information requested below so that we may keep our records up to date. Thanks!

Child's Name: _____

Pediatrician's Name: _____

Specialist Doctor's Names: _____

_____

Parent/Caregiver Name (1): _____

Phone: **Home:** _____

Cell: _____

Work: _____

Email: _____

Address: _____

_____

Parent/Caregiver Name (2): _____

Phone: **Home:** _____

Cell: _____

Work: _____

Email: _____

Address: _____

_____