The Children's Therapy Center

Telehealth Patient Consent and Authorization Form

Patient Name:
I hereby authorize The Children's Therapy Center and its staff to provide the above-named patient therapy as prescribed by my physician and recommended by the therapist, through the method of telehealth/telemedicine. I understand that I am obligated to remain present during all sessions. I have read and understand the above consent. I authorize payment directly to The Children's Therapy Center and its employees for telehealth services provided to my child. This is a direct assignment of my rights and benefits under my insurance policy. I understand that all of my previous consents regarding billing responsibility, cancellations and no-shows, remain in effect. I hereby give permission for my child to be on video and potentially recorded during the telehealth sessions.
Parent/Guardian Signature: Date:

Due to the fact that our offices are closed, and most staff are working only remotely, please contact your pediatrician in the event that you have any medical concerns about your child or their condition between therapy sessions. Please know that while we would like to be able to address your concerns as soon as you have them, that is just not possible at this time.