TREATMENT AGREEMENT

I understand that therapy results cannot be guaranteed. I will play an active role in my child's therapy program including assisting the therapist in identifying areas of need, establishing treatment goals, monitoring progress and carrying out recommended home programs. My child's progress will depend on many factors, including the neurological make-up of the individual, motivation, effort, regular attendance, and home follow-through.

Therapy may require of skin and physical skin-to-skin contact. My child will be physically active during therapy and injury may occur despite full efforts to provide safe activities in a safe environment. I will promptly notify my therapist of any activities that I feel are unsafe or inappropriate for my child.

Therapy at Play, Inc. may use information about my child in educational presentations. My child's identity will remain confidential.

Comprehensive evaluation includes:
- review of medical records as appropriate
- clinical time with child
- a written report

I understand that payment must be made at time of service, via cash or check. If medical insurance is being billed, I am required to pay all co-pays, deductibles and out-of-pocket costs prior to services being rendered. I am responsible for all fees not paid by insurance. ____Initials

_____ _____
Signature of parent Date

_____
Child's name

EMERGENCY MEDICAL RELEASE

I give my permission for Therapy at Play, Inc. to seek emergency medical attention for my child.
Special instructions in an emergency:

_____

_____

_____ _____ _____
Signature of parent Print name Date