Form Release

Client Copy _____   Company Copy _____

I understand and have been provided with a Notice of Privacy Practices for Protected Health Information also known as "PHI' which provides a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Patient Printed Name ____

Signature ____   Date __________________________________

Patient Name ____   Date of Birth:__________________________________

AUTHORIZATIONS AND RELEASES

ALL AUTHORIZATION AND RELEASE OF INFORMATION ON THIS FORM ARE VALID FOR THE DURATION OF TREATMENT UNLESS THE CLIENT CANCELS THE AllTHORIZATION BY A WRITTEN NOTICE to 10371 Stella Link Houston, TX 77025.

PLEASE INITIAL WHERE INDICATED.

CONSENT FOR TREATMENT

I the undersigned, voluntarily consent to the rendering of care, including treatment, evaluation and home program. I understand that I am under the care and supervision of the performing provider. (Initial) _____________

AUTHORIZATION/ASSIGNMENT TO PAY BENEFITS

I the undersigned, hereby authorize payment of medical benefits, if any, to ______________________________________. (Initial) I understand that I am financially responsible for my child's treatment charges and supplies including co-pay, deductibles and amounts not covered by this assignment of benefits. (Initial) _____________

AUTHORIZATION TO DISCUSS CLINICAL CARE

I the undersigned, hereby authorize ______________________________________ and/or their employee/contractors, to discuss clinical care with other therapists and professionals as needed to provide good care. I also realize that, other therapists and students may observe treatment sessions in the open gym area. (Initial) _____________

Form Release

RELEASE OF INFORMATION

I, the undersigned, hereby grant consent to ____________________________________, to use and disclose protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices for Protected Health Information provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review the Notice of Privacy Practices for Protected Health Information before you sign this release. The Notice of Privacy Practices for Protected Health Information is subject to change. If we change our notice, you may obtain a copy of the revised notice by phone request at 832-304-1093. You may request the right to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request, however, if the decision to grant your request is accepted, we are bound by our agreement.

You have the right to revoke this release in writing , except to the extent that we may have already used or disclosed your protected health information in reliance on your consent (Initial) ____________

AIITHORIZA TION FOR VIDEO/PICTORIAL CLINICAL RECORDS

I, the undersigned, authorize Therapy at The Zone therapists and/or their contractors to use non identifying videotape or photographs to assist with clinical evaluation, record keeping and/or teaching purposes. (Initial) ____________

Signature of Parent or Guardian ____ Date _______________________