

# NeuroPlay Studio™ LLC

*Pediatric Occupational Therapy*

**Phone:** (352) 729-1796

**Email:** connect@neuroplaystudio.com

**Service Area:** Central Florida  
Lake • Orange • Seminole Counties



NEUROPLAY STUDIO

*Pediatric OT*

## CONSENT FOR TREATMENT

### Patient Information

**Patient Name:**

**Date of Birth:**

### Consent for Occupational Therapy Services

I, the undersigned, hereby authorize NeuroPlay Studio™ LLC and its licensed occupational therapists to provide occupational therapy evaluation and treatment services to the patient named above.

**I understand that occupational therapy may include, but is not limited to:**

- Evaluation and assessment of developmental, sensory, motor, and functional skills
- Therapeutic activities to improve fine motor, gross motor, and visual motor skills
- Sensory integration and sensory processing interventions
- Activities of daily living (ADL) training
- Feeding therapy and oral motor interventions
- Handwriting and school-readiness activities
- Parent/caregiver education and home program development
- Consultation with other professionals involved in my child's care

**I understand and acknowledge that:**

- Therapy outcomes cannot be guaranteed, and progress varies by individual
- I have the right to ask questions about any evaluation or treatment procedures
- I have the right to refuse or discontinue treatment at any time

- I will be informed of any significant changes to the treatment plan
- My child's participation and cooperation are essential for optimal outcomes

### Assumption of Risk

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I understand that occupational therapy activities may involve physical movement and sensory experiences. While safety precautions are taken, there is an inherent risk of minor injuries (such as bumps, bruises, or muscle soreness) during therapy activities. I agree to notify the therapist immediately of any concerns or adverse reactions.

### Financial Agreement

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I understand that I am financially responsible for all services rendered. I agree to pay for services at the time of treatment or as otherwise arranged. I understand that NeuroPlay Studio™ LLC currently operates on a private pay basis.

### Photography/Video Consent (Optional)

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- I consent to photographs or videos being taken of my child during therapy sessions for treatment documentation and progress monitoring purposes only.
- I consent to photographs or videos being used for educational or marketing purposes (social media, website, etc.). I understand I may withdraw this consent at any time.

### Emergency Medical Authorization

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In the event of a medical emergency, I authorize NeuroPlay Studio™ LLC staff to seek emergency medical treatment for my child and to contact the emergency contact listed on file.

### Signatures

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By signing below, I confirm that I have read and understand this consent form, have had the opportunity to ask questions, and voluntarily consent to occupational therapy services for my child.

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Parent/Legal Guardian Signature

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Date

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Printed Name

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Relationship to Patient

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Witness Signature (Staff)

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Date

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Confidential Patient Information — Protected under HIPAA