



New Patient Consent to the Use and Disclosure of Health Information for treatment, payment, or operations

I _____, Parent/Guardian of _____, understand that as part of my child's services, Chatterbox Pediatric Therapy Center (CB) originates and maintains paper and/or electronic records describing my child's service history. I understand that this information serves as:

- A basis for evaluation and therapy treatment.
- A means of communication among the many health professionals who contribute to my child's care.

I am aware that CB has a Notice of Privacy Practice that provides a more complete description of information uses and disclosures. I understand that I may request a copy of the Notice if I so desire. I also 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 child's information may be used or disclosed to carry out treatment, payment, or therapy sessions.

I also give permission for my child to receive an evaluation and/or therapy services provided by CB. Payments are due at the time of visit unless other arrangements have been made. Please sign below stating that you have read the above mentioned Finance and Cancellation Policies and agree to their terms.

Signature: _____

Date: _____