CONSENT FOR EVALUATION AND TREATMENT

Child Name:_____ Date of Birth: _____

Consent for Evaluation and/or Treatment

 I give permission to ABC OT Services, Inc., its agents or employees to provide clinical services as needed for me and/or my minor child/ward. I have discussed all the relevant reasons for requesting the evaluation and/or treatment and understand the services that will be provided.

Limits of Confidentiality

 I have been informed and understand that information conveyed to ABC OT Services, Inc., its agents or employees is confidential except in the following situations according to California State Law:

a) If I/my child communicate(s) to ABC OT Services, Inc, its agents or employees that a serious threat to harm an identifiable person is intended, we must warn the identified person and the police;

b) If, ABC OT Services, Inc., its agents or employees suspects child abuse or neglect, or abuse of a helpless adult or elder, a report must be made to the appropriate agency; and

c) If I/my child appear(s) to be a danger to my/him/herself or others, hospitalization may be necessary.

Signature: _____ Date: _____