399 Ridge Road, Suite 4 & 5 Dayton NJ 08810, (815) 66A-KHIL

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

By signing this form, you acknowledge that you have received the Notice of Privacy Practices of The Sensory Pathway Center, which provides information about how your child's protected health information may be used and disclosed. We encourage you to read the notice in full.

Your signature on this form indicates your consent for The Sensory Pathway Center to disclose your child's appropriate health information for the purpose of analyzing, diagnosing, or providing treatment to your child, obtaining payment for your healthcare bills, or conducting research.

You have the right to request a restriction on how your child's health information is used or disclosed for treatment, payment, or practice operations.

"Protected health information" for your child refers to health information, including demographic information, collected from you and created or received by the treating therapist, related to your child's past, present, or future physical or mental health or condition, and that identifies your child.

Please note that our Notice of Privacy Practices is subject to change. In the event of any changes, we will provide you with the revised notice, or you may obtain a copy by contacting The Sensory Pathway Center at (insert contact information here). If you have any questions or concerns regarding our Notice of Privacy Practices, please do not hesitate to contact us.

Name of client: _____

_____ _____

Signature of Legal Guardian Printed Name of Guardian

_____ _____

Relationship of Legal Guardian Date of signing