Permission To Evaluate and Provide Physical Therapy Services

_____
Printed Child's Full Name and Date of Birth *

_____
Printed Name of Parent/Guardian *

_____
Signature of Parent/Guardian and Date *

Please complete this form to grant permission for Transitional Steps Pediatric Physical Therapy Services, LLC to evaluate your child's gross motor skills as well as provide necessary treatment as needed.

I _____ , authorize Transitional Steps Pediatric Physical Therapy Services, LLC to evaluate and provide the recommended physical therapy to _____ .

Therapy/treatment is contingent upon the results of the evaluation and the impending recommendations of the responsible physical therapist.

Insurance Provider

Policy/Subscriber ID Number

Group Number

By signing this you authorize Transitional Steps Pediatric Physical Therapy Services, LLC to bill the patient's insurance as well as accept payment for any services rendered.

Signature of Parent/Guardian and Date *_____

Is treatment required as the results of an employment injury, auto accident or other accident? *

○ Yes ○ No

If yes, please explain: