P.O. Box 670207 Marietta, GA 30066
Office 678-503-8702, Fax 678-503-8912
www.koolkidzpt.com

CONSENT FOR THERAPY

I, _____, acting on behalf of

_____ (hereinafter referred to as "the Patient")

consent to the necessary care and/or treatment of the patient by the therapists doing business for Kool Kidz, Inc. I consent to care and treatment that falls within the scope of physical/occupational therapy practice as defined by the State of Georgia and the American Physical Therapy Association. I understand that the practice of medicine, including physical/occupational therapy, is not an exact science and that treatment will involve physical participation on the part of the patient which may involve risks of injury. I acknowledge that no guarantee has been made to me as the result of evaluation and/or treatment.

I consent to the taking and publishing of still or motion pictures of the patient's diagnosis and treatment. I further agree that the information from the patient's medical record may be disclosed for educational and/or research purposes.

I understand that the patient's valuables and personal belongings are my responsibility and that Kool Kidz Inc. shall not be responsible or liable for any loss, theft, misplacement, or damage of personal belongings.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE CONTENTS AND AM COMPETENT TO EXECUTE IT OR IF EXECUTED ON BEHALF OF ANOTHER, I AM AUTHORIZED TO EXECUTE IT ON BEHALF OF THAT PERSON.

Signature of patient or person authorized to consent _____ Date _____

Relationship to patient _____