Mini Miracles Pediatric Therapy
"Serving Families and their Mini Miracles"
East Fairview Ave., Johnson City, TN 37601; ph: 423-928-6464; fax 423-232-7970
225 Midway Medical Park, Bristol, TN 37620; ph:423-797-4555; fax: 423-797-4556

VIRGINIA SCHOOL THERAPY INFORMATION and PERMISSIONS

Child's Name:	Today's Date:
Child's Date of Birth:	School:
Teacher/Case Manager:	Grade:

CONTACT INFORMATION Best Way to Contact: Phone Call ☐ Text ☐ (*please circle best number to use*)

Mother:	Phone:
Father:	Phone:
Guardian/Other:	Phone:
Address:	
Is this child in the foster care system? □ No □ Yes If yes, DCS Caseworker NAME: ____ PHONE:__________________	
Does Your Child Have Any Allergies? □ No □ Yes (please list here)	
Does your child have specific medical needs or precautions while at school?	
Pediatrician:	Medical Diagnosis:

CONSENT TO EVALUATE AND TREAT

I authorize Mini Miracles Pediatric Therapy to assess and provide occupational, physical, and/or speech therapy treatment necessary, as determined by IEP team, to improve my/my child's functional, developmental, or medical level of functioning.

When my child's education plan (IEP or Service Plan) with the school system includes distance learning, I give permission for Mini Miracles Pediatric Therapy to utilize teletherapy for any related services they provide. I agree that I will not record any MMPT teletherapy sessions. When a child participates in telehealth therapy, it is the responsibility of the patient/caregiver to communicate through devices that they know to be secure and to choose a secure location to interact for sessions with technology-assisted media.

Signature of Parent/Legal Guardian____ Date____________________

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PATIENT RIGHTS

The purpose of this written statement is to inform you and/or your child of your rights as a patient. If you need help understanding this, please ask your therapist.

1. You and/or your child have the right to competent, considerate, and courteous treatment without discrimination.
2. You have the right to complete information and to ask questions about all the aspects of your/your child's therapy, including all providers and charges associated with therapy.
3. You have a right to be involved in all aspects of your/your child's therapy treatment.
4. You and/or your child have the right to agree to or refuse to participate in any aspect of therapy.
5. You and/or your child have the right to assistance with communication, including an interpreter if necessary.
6. You have the right to discuss ethical issues arising in your/your child's care.
7. Your therapist is a mandatory reporter for abuse and neglect, therefore any signs of abuse/neglect will be reported immediately to the proper authorities.

RELEASE OF MEDICAL INFORMATION

I authorize Mini Miracles Pediatric Therapy to release any medical/treatment information to my child's physician, school staff and administrators, as well as any other service provider on my/my child's treatment team to share medical/treatment information pertinent to the plan of care or billing. I give Mini Miracles Pediatric Therapy permission to contact my child's physician regarding evaluation and treatment services referred or received.

CONSENT TO PHOTOGRAPH

I understand that photographs, video, and/or digital images may be made or recorded during therapy to document progress or for educational purposes. I understand that Mini Miracles Pediatric Therapy (MMPT) will keep such information confidential and will maintain my privacy. Any such images will be kept for a length of time according to the law and families can request copies of them. Any images that identify you/your child will only be released or used only upon written authorization for purposes such as lecturing/marketing.

☐ I do not give consent for my child to be photographed. Initials _____

CONSENT TO USE PHI

I consent for my child's Patient Health Information to be used by Mini Miracles Pediatric Therapy or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office only.

NOTICE OF PRIVACY PRACTICES

I have received and reviewed the Notice of Privacy Practices for a more complete description of how Patient Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

Print CHILD'S Full Name: ____

Parent/Guardian Signature: ______________________________ Relationship to child: _________________ Date: _____________

Witness Signature: ____ Date: ____________