



I authorize Bloom Pediatric Therapy to render appropriate evaluation and therapy services to the child named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Bloom Pediatric Therapy in writing. In addition, Bloom Pediatric Therapy may terminate services by notifying me in writing.

I do not give my consent or am withdrawing my consent regarding Bloom Pediatric Therapy rendering evaluation and therapy services to the child named below.

Print Name of Child

Date

Child Date of Birth

Signature of Parent or Legal Representative

Relationship to Child