



COMMUNICATION CIRCLES

RELEASE OF PRIOR AUTHORIZATION and CONSENT FOR TREATMENT

The undersigned voluntarily CONSENTS TO AND AUTHORIZES such speech therapy, occupational or physical therapy evaluation and treatment as the licensed therapists through THERAPY CIRCLES, PLLC/ Elizabeth Furler. A plan of treatment, including goals of treatment, is developed by the patient/parent and the therapist together after an initial evaluation of the problem is performed. This plan is sent to the referring physician for approval. The patient acknowledges that no guarantee has been given as to the outcome of this therapy plan of care.

The undersigned consents to the release of prior authorization for therapy from any other speech pathologists, occupational or physical therapists, therapy clinics or home health agencies. The last date of treatment with the prior therapist was on _____ with _____ . Speech therapy/Occupational/Physical therapy services with THERAPY CIRCLES, PLLC/Elizabeth Furler began on _____. The undersigned acknowledges he/she has chosen THERAPY CIRCLES, PLLC/Elizabeth Furler as the provider of speech/physical/occupational therapy for his/her child, _____. This decision was voluntary.

Signature of Responsible Party

Date

Patient's Name (if responsible party is not the patient)

Relationship to Patient