SALUS UNIVERSITY
Occupational Therapy Institute

____Notice of Client Rights & Responsibilities: I acknowledge that I have received and read a copy of the Client Rights and Responsibilities form.
____Notice of Privacy Practices: I acknowledge that I have received and read a copy of the Notice of Privacy Practices that describes my rights regarding my health information and how my health information may be used or disclosed.
____Authorization to Release Medical Information: I authorize the Occupational Therapy Institute to release my medical information to my referring physician, nurse practitioner, or other clinicians involved in my treatment in order to coordinate care.
____Consent to Treat: I give my consent to the Occupational Therapy Institute students and licensed supervisors to provide outpatient therapy services considered necessary and proper for my diagnosis. I understand that I may refuse treatment at any time. My initials above and my signature below indicate consent to all of the above.
____Consent to Treat: I understand that I can be treated at the Occupational Therapy Institute for two consecutive semesters, followed by a break in care for one semester. This is to provide equity for other patients on the waitlist, and to provide patient diversity for student learning. If appointments become available during my break period, I may be offered another evaluation as time allows.
____ Consent to Treat: I understand that I need a new prescription every semester (January, May, and September) to continue my plan of care at the Occupational Therapy Institute.
____ Consent to Treat: I understand that I may be discharged from the Occupational Therapy Institute if more than three sessions in a three months period are canceled or not attended (i.e. no show) without notice to the clinic staff.

Release for educational and teaching purposes
I, _____, authorize the therapists at the Occupational Therapy Institute, to be observed and or receive therapy during sessions by fieldwork students/interns and/or volunteers in our usual practice. I understand that these individuals will be signing confidentiality agreements as mandated by HIPAA and that any information will be used for teaching purposes only.

Signature: _____
Patient Name:_____
Date:_____