Consent for Participation

I understand that the treatment and/or evaluation will be observable by patient family members through the group observation area. I am aware that other parents, guardians, and family members will also be in the observation sessions and may be able to see or hear my child’s and/or family member’s therapy session.

I understand that as part of the treatment and/or evaluation process, aspects of the process will be videotaped for the educational process of the student, for analysis of patient communication, and for educational activities within the department. These videotapes will be used in the treatment and/or assessment process and will be destroyed when the information gathering process is complete or will be kept in a secure location within the department.

I understand that I can withdraw from my participation at any time during this experience and revoke my permission to use the information pertaining to my case. If I elect to withdraw and revoke my permission, I will inform the Clinic Director and the Department Chairperson of this action in writing. I further understand that a copy of this form will be given to me upon my request, and the original will be kept on file in the Department of Physical and Occupational Therapy.

If the clinic submits bills to my insurance company, I authorize payment of the medical benefits to the ISU Physical & Occupational Therapy Associates for the services provided.

________________________________________________________________________

Print Name of Patient or Personal Representative  Date

________________________________________________________________________

Signature of Patient or Personal Representative

________________________________________________________________________

Witness Signature  Date

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent  ☐ Guardian  ☐ Power of Attorney  ☐ Other: ___________________________________________

Updated: 08/28/14