THERAPY PARTICIPATION AGREEMENT

Child's Name: ______________________________

The HSC Pediatric Center is committed to providing your child with quality care. Your child's success depends on good attendance in therapy and carryover at home. Please read through the Therapy Participation Agreement and sign at the bottom to indicate that you have read, understand and agree to the following policies.

TIMELINESS OF ARRIVAL

- Please arrive prior to your scheduled appointment in order to begin therapy sessions on time.
- You will not be seen if you arrive 15 minutes late for treatment sessions lasting 45-60 minutes and will be asked to reschedule.
- Aquatic therapy sessions require patient to arrive at least 15 minutes prior to the start time of the scheduled appointment time to ensure the patient is ready to enter the pool at his/her scheduled appointment time. A patient is considered late if they arrive five (5) minutes past the start of the scheduled aquatic appointment time and are not dressed and prepared to enter the pool immediately
- Sessions that begin late will end on time.
- If you show a pattern of late arrivals, you will be discharged from future treatment sessions.

CANCELLATIONS/NO SHOWS:

- If you need to cancel an appointment, please call the front desk of the appointment location:
  - DC: **(202) 635-5580**
  - Rockville: **(301) 560-2285**
  - Lanham: **(301) 560-3640**
- We respectfully request that you provide at least a 24 hour notice of planned cancellation by notifying the front desk. Communication to the therapist alone is not sufficient to cancel an appointment.
- If you show a pattern of missed sessions, you will be discharged from future treatment sessions.
  - Exceptions may include medical and/or insurance hold not to exceed 2 weeks; therapist absences.

ON-SITE RULE

- It is mandatory that a guardian/caregiver stay on premises, preferably with the child or in the outpatient waiting area during their appointment.

(cont.)

THE HSC HEALTH CARE SYSTEM

The HSC Outpatient Center

ILLNESS/ SURGERY

These rules are for EVERYONE receiving Outpatient services.

- Please **DO NOT** come to therapy if you or your child:
  - Are contagious with a communicable disease (e.g. chicken pox or whooping cough).
  - Have vomiting or diarrhea.
  - Have a cough, runny nose or other flu-like symptoms.
  - Have a fever greater than 100 degrees, rash, lethargy or irritability.
  - Have strep throat or pinkeye. You may attend therapy 24 hours after medication has started.
  - Have undiagnosed or untreated rash.
- If your child is hospitalized or undergoes a medical procedure (i.e. Botox injections), you must obtain a new order from your doctor to resume therapy.

EQUIPMENT

- If your child uses equipment (tracheostomy supplies, ventilator batteries, hearing aids, walkers, braces, wheelchair, speaking valve, augmentative device, etc.) you must bring the items to all therapy sessions.
- If your child requires supplemental/portable oxygen, they must arrive with enough oxygen to complete the session and be transported back to the home, otherwise in effort to maintain the patient's safety, they will may not be seen or able to complete the full session.
- If the patient does not come with their necessary equipment, the appointment may be cancelled, as the therapist may not be able to provide safe or effective therapy.

HOME PROGRAM/THERAPY CARRYOVER

- Participation and carryover of your child's home program is vital to assist your child in meeting the established therapy goals.
- Not following the established home program recommendations may result in decreased progress and/or discharge from therapy.

We are open Monday through Friday from 8:00 a.m. to 6:00 p.m.
Voicemail is available 24 hours a day.

I have read and agree to the above policies.

______________________________	____________________
Parent/Guardian Signature	Date
______________________________	____________________
Signature of Witness	Date

(Patient Name) (HSC #) (Birth Date)

PARENT/GUARDIAN'S DESIGNEE TO PARTICIPATE IN CHILD'S TREATMENT

In general, a child should be accompanied by a parent or legal guardian when receiving medical treatment. However, there may be instances when someone other than a parent or legal guardian will need to accompany a child for his/her medical treatment. In such an instance, the person accompanying a child must have the permission of that child's parent or legal guardian to be present and participate in that child's treatment.

By completing this form, you are identifying your authorized "Designee," the individual who may accompany your child during treatment when you are unable to be present. **Please note that the Designee must be 18 years of age or older.**

Instructions for Use of this Form

1. **Use a separate form for each child**.
2. Complete all the information on Pages 2 of this form for each child.
3. Give the completed form to Front Office Staff (which includes page one and two of this form). A copy of the form will be kept in your child's medical record; however, the person(s) you have chosen to represent you should still bring a copy with them each time they come in with your child.
4. This consent will be valid for the duration of your child's treatment. **It is your responsibility to inform HSC Pediatric Center of any changes.**
5. **To revoke the form, you will need to complete the required information on Page 3 and submit it to Front Office Staff.**
6. Please make your designee aware that it is very important that they obtain any patient instructions in writing, when indicated, before leaving the appointment. If you have questions about the instructions, please contact your child's therapist.

Please note: By signing the form below, you voluntarily authorize HSC Pediatric Center to disclose your child's confidential information to the Designee listed below, including all of your child's health information that HSC has in its possession, including information relating to any medical history, physical condition and any treatment received by the patient.

____ _____________________________________

(Patient Name) (HSC #) (Birth Date)

PARENT/GUARDIAN'S DESIGNEE TO PARTICIPATE IN CHILD'S TREATMENT

I, (parent/legal guardian) ____________________, cannot accompany my child, (patient's name)___________________ to outpatient services. Therefore, I give permission to (person's name/entity)___________________ to be present and participate in my child's treatment and services, including in any education and training that is scheduled for the session. Additionally, I give my Designee consent to access my child's personal health information (PHI).

Signature of parent or legal guardian ______________________________

Date signed ____________________

Address_______________________

Home Phone___________________

Signature of Designee: ______________________________

Date signed ____________________

Address_______________________

Home Phone___________________

____________________________ (Patient Name)

____________________________ (HSC #) (Birth Date)

THE HSC HEALTH CARE SYSTEM

The HSC Outpatient Center

NOTICE TO REVOKE "DESIGNATION OF ANOTHER PERSON TO CONSENT FOR TREATMENT" FORM

I, (parent/legal guardian) _________________________, am the parent of (child's name) ____________________________. Please immediately revoke prior permission for (person's name) ______________________________ to consent to be present and participate in my child's treatment and services.

Signature of parent or legal guardian ______________________________

Date signed ____________________

Address_______________________

Home Phone___________________

In order to process your Notice to Revoke, please bring this form with you to your next visit or email to recordrequest@hschealth.org. Thank you.

Hospital Use Only:

Revoked by (staff name): ________________________________

Date of Revocation: ____________________________________