# HEALING THERAPEUTIC SERVICES, LLC
# PARENTAL CONSENT and MEDICAL LIABILITY RELEASE

## *CLIENT INFORMATION*

Client Name: _____ Age: _____ DOB: _____

Address: _____
City, State, Zip Code

Phone Number: _____ Cell Number: _____Work Number: _____

Medical Insurance: YES _____ NO _____ Insurance Company _____

Policy Holder: _____ Policy Holder DOB: _____

Policy ID #: _____ Policy Group #: _____

Allergies or Medical Conditions & Medication(s): _____

## *PARENT / GUARDIAN INFORMATION*

Name of Parent / Legal Guardian: _____

Address of Parent / Legal Guardian: _____
City, State, Zip Code

Phone: Day _____ Evening _____ Cell _____

## *EMERGENCY CONTACT INFORMATION*

In case of a medical emergency should the parent or legal guardian cannot be reached.

Name: _____

Relationship to Client: _____

Address: _____
City, State, Zip Code

Phone Number: _____ Cell Number: _____Work Number: _____

## *CONSENT and MEDICAL LIABILITY RELEASE*

***I give permission for my child / client named above to participating in activities, events that may take place outside the office of Healing Therapeutic Services, LLC during any scheduled therapy session. This will include transportation driven by our clinical staff member(s). My child / client named above and I understand that SEAT BELTS SHALL BE WORN AT ALL TIMES during transportation. This authorization and consent will expire one year from this signed consent and release document.***

***I hereby release, indemnify and hold harmless Healing Therapeutic Services, LLC its staff members and agents from any and all liability, damage, claim of any nature whatsoever arising out of or in any way related to participating in outside events or activities during any scheduled therapy session, including transportation to and from the office of Healing Therapeutic Services, LLC.***

***I authorize and consent to the giving of all treatments, medications, and or emergency care should the need arise. We further authorize the use of disclosure of my personal health information should medical or emergency treatment become necessary.***

_____ _____/ _____

Name of Parent / Legal Guardian (Printed) Signature of Parent / Guardian Date

*Office Use Only: Copy of Signed Consent and Release given to Parent / Legal Guardian. Date:* _____ *Staff Initials:* _____