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**Therapy Consent Form for Special Needs Child**

**1. Basic Information**

* **Child's Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Parent/Guardian's Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Therapy Details**

* **Type of Therapy:** ☐ Speech therapy ☐ Occupational therapy ☐ Physical therapy  
  ☐ Sensory integration therapy ☐ Behavioral therapy ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_
* **Therapist’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Session Frequency:** ☐ 1x per week ☐ 2x per week ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_
* **Duration of Therapy:** 3 months from start date  
  **Start Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  **End Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Terms and Conditions**

* **Session Fee:** £10 per hour.
* **Deposit:** A refundable deposit of £25 is required before starting therapy.
  + The deposit will be refunded after successful completion of the 3-month therapy period.
  + If the family does not complete the 3-month sessions, the deposit will not be refunded.
* **Payment Terms:** Fees are to be paid at the start of each session or as agreed upon with the therapist.

**Cancellations and Refunds:**

* **Cancellation Policy:** Please notify us at least 24 hours in advance if a session needs to be canceled. Missed sessions without proper notice may be charged the full session fee.

**End of Therapy:**

* At the conclusion of the 3-month therapy period, a review will be conducted to assess the child’s progress and discuss any continuation of services if needed.

**4. Media Consent**

* **Photography/Video:** I, the undersigned, grant permission for the child to be photographed and/or videotaped during therapy sessions for the purpose of therapy documentation, training, or promotional materials.  
  ☐ Yes ☐ No
* **Use of Images on Social Media:** I, the undersigned, grant permission for the child’s images or videos to be used on the clinic’s website or social media channels (names and identifying features will be anonymized if requested).  
  ☐ Yes ☐ No

**5. Confidentiality**

* All personal and therapy-related information will remain confidential and will only be shared with relevant professionals involved in the child’s care, unless otherwise authorized by the parent or guardian.

**6. Parent/Guardian Consent**

I, the undersigned, hereby give my consent for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child’s name), to participate in therapy services provided by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (therapist’s name) under the terms and conditions listed above. I understand the fees, session duration, and the deposit policy. I also understand and agree to the terms of media consent as indicated in this form.

**Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact : +44 7938 641964, E-Mail :** [**sidra.ifzal@autismfamilysupport.uk**](mailto:sidra.ifzal@autismfamilysupport.uk)**,**

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