MEYER CENTER FOR SPECIAL CHILDREN

Child's Name:_____

THERAPY PERMISSION

Permission ☐ **is given** ☐ **is not given**

for my child to receive physical, occupational or speech therapy evaluation and treatment services provided by registered therapists as prescribed by my child's physician. I release the Meyer Center for Special Children staff and/or contracted therapists from any liability in connection with said treatments.

_____ _____

Parent/Guardian Signature **Date**

SC MEDICAID CONSENT TO BILL/ RELEASE OF INFORMATION

I understand that if my child is Medicaid eligible, Meyer Center will bill the South Carolina Medicaid Program for these services. By signing this form I give Meyer Center permission to bill the Medicaid Program and to release to the Medicaid Program any information related to these services that may be necessary for the processing of Medicaid claims.

_____ _____

Parent/Guardian Signature **Date**