Melanie Arazi BSc Hons MCSP HCPC APCP

Highly Specialist Paediatric Physiotherapist

www.childrensphysioclinic.co.uk

Consent for Physiotherapy Treatment and Cancellation Policy Form

Child's Name:

Date of Birth:

Home Address:

Email Address:

Telephone Number:

I confirm that I have read the information below and consent as follows (please tick all boxes):

- ☐ I, the parent / guardian of the child named above, consent to physiotherapy assessment and treatment of my child as deemed appropriate by the physiotherapist working on behalf of The Children's Physiotherapy Clinic.
- ☐ I have had the opportunity to ask any questions I may have prior to assessment.
- ☐ I am aware I am liable for any fees as confirmed by The Children's Physiotherapy Clinic and in accordance with its Terms and Conditions. The Terms and Conditions can be accessed online at: www.childrensphysioclinic.co.uk
- ☐ I am aware that I may withdraw consent for further assessment and treatment at any time.
- ☐ I am aware that individual appointments cancelled in under 48 hours (apart from Monday appointments which must be cancelled by 9am on the preceding Friday) will be liable for a full cancellation fee and any travel time due. I agree to be bound by the cancellation policy detailed in the Terms and Conditions.

Signed: …… **Relationship to Child:** ……

Name: …… **Date:** ……

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