CONSENT FOR SEATING AND POSITIONING SERVICES

The Department of Intellectual and Developmental Disabilities (DIDD) Seating and Positioning Clinics employ occupational and physical therapists that have specialized expertise in evaluating complex wheelchair seating and therapeutic positioning needs. Our comprehensive seating and positioning evaluations consist of reviewing health history, issues with current equipment, goals and outcomes, and completion of a thorough mat assessment. Once the evaluation is completed, the therapist, the client and any caregivers present, determine needed treatment goals. Treatment consists of simulation to determine specifications for equipment, fittings for adjustments as needed, and training on the equipment for those present at delivery. Our clinicians work hand in hand with a durable medical equipment vendor of the client's choosing (based on the client's insurance provider) and others as needed to identify funding options for necessary equipment.

Our therapists take the time to communicate with and listen to clients and caregivers in order to meet expressed needs. They educate about the benefits of recommended interventions and equipment, but they also respect the client's right to refuse any aspect of treatment. Guardians and conservators are highly encouraged to attend any and all appointments with the client.

Consent for Evaluation and Treatment

I recognize that I am free to choose any provider of the above services and have elected to choose the DIDD Seating and Positioning Clinic. I understand these services will be provided by a licensed occupational or physical therapist (depending on clinician availability) employed by the DIDD Seating and Positioning Clinic. *I hereby consent for the DIDD Seating and Positioning Clinic to provide an evaluation and treatment for wheelchair seating and therapeutic positioning needs for the below-named client.*

I understand that the DIDD supports college and university health-related programs by contracting with schools to accept students completing clinical fieldwork. These students are required to pass background checks and follow the DIDD privacy practices and other relevant policies while at the DIDD. *I consent to allowing clinical students to observe and/or work with the client under full time supervision of a licensed therapist.*

I understand that the DIDD Seating and Positioning Clinics also have in-house manufacturing of custom equipment including molded wheelchair seats and backs, other customized wheelchair components as needed, and custom positioning equipment. *If custom equipment or customization of commercially available equipment is needed, I authorize the DIDD to manufacture this equipment or components.*

The Functional Mobility Assessment (FMA) self-report questionnaire is an outcome measure tool that helps us know if mobility equipment recommended and delivered to the client helps to meet his/her goals and improves his/her quality of life. The DIDD is partnering with U.S. Rehab to utilize this tool when a new wheelchair is needed. A special version of the tool is available if the client needs help answering the questions. *I authorize the completion of the Functional Mobility Assessment questionnaire by the client, his/her family, or his/her direct support professional at his/her initial appointment as well as subsequent phone or mail follow up by U.S. Rehab staff at approximately 21 days, 90 days, 180 days, 365 days, and annually thereafter in order to capture any issues with the wheelchair and ensure that any issues are resolved for the client. I understand I can withdraw from this process at any time as it is voluntary.*

Benefit Assignment/Release of Information

I hereby assign all benefits, including major medical benefits to which I am entitled such as Medicare, Medicaid, private insurance, and/or third party payers, to the State of Tennessee, DIDD Seating and Positioning Clinics. I hereby authorize the DIDD Seating and Positioning Clinics to release my medical information, to my health insurance or third party payer in order to secure payment.

I agree to pay any applicable co-payments, coinsurance and/or deductibles upon being billed. I understand that I may be responsible for any charges not covered by my health insurance or third party payer. I understand that I will be notified up front if a requested or recommended piece of equipment may not be funded through insurance or other sources in order for me to determine if I want to pay for the item on my own.

Use and Disclosure of Health Information

I have received and had an opportunity to read the DIDD Notice of Privacy Practices. I understand that by signing this consent, I am giving the DIDD Seating and Positioning Clinic consent to use and disclose my protected health information in order to carry out treatment and payment of benefits as outlined above and in the notice. I understand that I can obtain an Authorization for Release form from the clinic as necessary in order to authorize the clinic to provide my records to be released for purposes not covered by the DIDD Notice of Privacy Practices. I am aware that the DIDD will always post on the DIDD website and/or make copies available in the clinic, the most up to date version of the DIDD Notice of Privacy Practices.

Consent Signature

I have read and understand the above information.

Client's Name: ____ Date of Birth:_______________________________________
(Please print)

Client or guardian/conservator signature:_____________________________________/_______________________________
(Signature) (Printed Name)

Date: ___________________________

Relationship if signed by person other than client: ____________________________