VIDEO TAPING/PHOTOGRAPHY CONSENT FORM

I, _____ give my consent for myself___ or my child____, _____, to be videotaped or photographed by S.M.I.L.E.S., Integrative Therapy Services, LLC ("S.M.I.L.E.S.") for any of the following purposes:

Education and/or Consumer Materials

For the purpose of creating educational and/or consumer materials that will describe the nature of S.M.I.L.E.S., its techniques, services, successes or aid in the understanding of cognitive, physical, and motor skills; speech, language, swallowing, feeding development; oral sensory motor function, delays or disorders and their treatment.

I understand that the above authorization may be rescinded at any time when presented in writing by myself or other authorized guardian to S.M.I.L.E.S.

_____
Patient's Name

_____ _____
Caregiver's Name Date

_____ _____
Witness Date

_____ _____

S.M.I.L.E.S. Integrative Therapy Services, LLC
1120 Cottonwood Drive, Suite #4, Loveland, OH 45140
www.smilestherapy.com
513.404.5915

Education and Treatment Planning

I understand that under this area that any videotape or photographs will be shown only to other professionals directly involved in the care and treatment of my child; other professionals who may be consulting to assist in a successful treatment outcome; or to provide feedback to my or my child's treatment. All information obtained in these evaluations/therapy sessions will be available to me and the video tape or photographs returned after above stated occurrences. I also understand that neither the videotape nor the photographs will be copied or utilized for any other purpose than stated above without my permission.

I understand that the above authorization may be rescinded at any time when presented in writing by myself or other authorized guardian to S.M.I.L.E.S.

Patient's Name

Caregiver's Name | Date

Witness | Date

General Research and Education

Any evaluation or therapy sessions may be videotaped or photographed or both for general research and educational purposes. They may be collected to aid in the collection of data. All or some of any video tape or photograph may be used in the teaching and/or training of allied professionals (i.e., SLPs, OTs, PTs, educators, etc.).

I understand that the above authorization may be rescinded at any time when presented in writing by myself or other authorized guardian to S.M.I.L.E.S.

Patient's Name

Caregiver's Name | Date

Witness | Date