Client Choice Statement

Client Name: ____ DOB: ________________

I, ____ (Patient/Parent/Guardian name) understand it is my right to select a healthcare provider of my choice. PHC has informed me if for at any time, for any reason I can chose to change my services to another healthcare provider, it is my right to do so. I have chosen Pediatric Healthcare Connection to provide the below services for:

____

PDN ______________

PT ______________

OT ______________

ST ______________

I, ____ (Patient/Parent/Guardian

name) request the above services for ______________________________________

(patient) be transferred from: ____

(current/previous provider) to Pediatric Healthcare Connection as of _____________ (date).

____ _____________
Patient/Parent/Guardian Signature Date

____ _____________
Agency Signature Date