1505 N Alma School Rd
Suite 2
Chandler, AZ 85224
Office: 480.626.4142
Fax: 480.626.7370

Authorization Discrepancy Consent

I, ___________________________________, acknowledge and accept that my
Print caregiver's first and last name

child ______________________________ is not receiving the authorized duration of
Print child's first and last name

__________________________________ my child currently qualifies for through DDD.
Type of therapy (OT, PT or ST)

I understand that it is fully up to my discretion if I prefer not to seek a different provider who could provide the authorized units of service for which my child currently qualifies.

___________________________________   _____________________
Parent/Guardian Signature   Date

___________________________________   _____________________
Witness (Therapist Signature)   Date