Jean Rogers, M.Ed, CCC-SLP

704-562-0088

INFORMED CONSENT FOR SPEECH THERAPY & TREATMENT

Patient's Name_____ DOB_____ Gender_____

Address_____ Phone_____

Email address_____

Insurance/Medicaid# with letter at end of the number_____

Practice Name_____ Physician's Name_____

Practice Address_____

Permission to evaluate and/or treat:

I, _____, the parent/legal guardian of _____

_____, hereby request and consent to Three C's Speech Therapy Services, PLLC to perform treatment and care for my child as prescribed by a physician and/or recommended by a speech-language pathologist. I understand and am informed that, as in the practice of medicine, speech language therapy may have some risks. I understand that I have carefully read and understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist. I consent and authorize Three C's Speech Therapy Services, PLLC to evaluate and administer treatment under the direction and supervision of a certified speech-language pathologist. This authorization also permits the sharing of medical and educational history for purposes of evaluation and treatment only.

_____ _____

Signature of parent/guardian Printed name of parent/guardian

_____

Date

Please return this form with your child as soon as possible.