Speak Freely

Speech–Language and Oral-Motor Services

Consent and Acknowledgement

Consent for Care and Treatment: As the child's parent or legal guardian, I hereby consent to necessary evaluation, procedures and/or treatments prescribed by my child's therapist as necessary in her judgment. I understand that my child is under the care and supervision of my therapist.

_____ _____

Signature of legal representative of child Date

Acknowledgement of Notice of Privacy Practices: I acknowledge Speak Freely will use and disclose my personal health information for treatment, payment, and other healthcare operations and as otherwise permitted by law. Our notice of Privacy Practices provides further detailed information about how we use and/or disclose protected medical information about your child for treatment, payment, healthcare operations, and as otherwise allowed by law.

_____ _____

Signature of legal representative of child Date

Consent for Student Observation: I understand that Speak Freely supports the education of students of Speech Pathology and that students may observe clients' in therapy.

□ I consent to have students in the same treatment area with my child.

□ I do not consent to have students in the same treatment area with my child.

_____ _____

Signature of legal representative of child Date