Parent / Guardian Consent Form

Patient Name: _____ Age: _____ Birth date: _____ M___F___

Name of Parents/Spouse/Guardian: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Mother Cell: _____ Father Cell: _____ Email address: _____

Patient's Physician: _____ Physician Phone: _____

I agree to have my child, _____, receive a speech language therapy evaluation and/or treatment.

Confidential Release of Information:

I hereby authorize Speech Source Therapy Inc. to obtain and/or release of pertinent information concerning _____. It is my understanding that this information will not be shared with any other entity without my prior knowledge. I further acknowledge that the use of this information is to ensure the best quality of care possible for my child.

Cancellation and No-Show Policies:

Speech Source requires 24 hours' notice of need for cancellation to be eligible for a make-up session. Make-up sessions must occur within 2 weeks of the cancelled session and are subject to availability. A make-up session with a substitute clinician may be necessary due to scheduling constraints.

Safety Policies:

Speech Source Therapy Inc. requires that all children under the age of 13 be accompanied in and out of the office by an adult, parent, or guardian. Children may not be left unattended in the waiting area or in the home. There is no supervision available. Patients must be accompanied by a Speech Source staff member to enter any treatment rooms, materials room, kitchen, or gym. The business office is for staff only.

I **consent** / **do not consent** to video/audio taping or photography for treatment purposes. Initials _____

I have received a copy of the Health Information Portability and Privacy Act (HIPPA) policy. Initials _____

I have read and agree to abide by the above policies. I understand that I may request a copy of this form at any time.

_____ _____

Signature of Responsible Party/Parent/ Guardian Date