INFORMED PERMISSION FOR TREATMENT

Child's Name: _____ **Child's DOB:** _____

I hereby grant permission to Therapy InSync LLC and its associates to perform Speech Therapy services as prescribed by a physician and/ or recommended by the Speech-Language Pathologist.

Initial all sections below:

_____ I. I have had the opportunity to discuss all risks of treatment with the provider prior to the above-named child's treatment.

_____ II. I understand and consent to authorize Therapy InSync, LLC to administer treatment under the direction and supervision of a certified and licensed Speech-Language Pathologist. In addition:

A. I have seen, understand, and agree with the treatment goals and therapy Plan of Care.

B. I agree to attend scheduled therapy sessions in accordance with Attendance Policy.

C. I agree to participate in my child's treatment as is directed and/or requested by Therapy InSync, LLC.

D. I agree to help my child at home to carry over the skills learned in therapy.

_____ III. I understand that Therapy InSync, LLC may accept graduate interns at the practice. I further understand and agree that a graduate intern may be present to observe or participate in treatment and will be appropriately supervised by a fully licensed Speech-Language Pathologist in accordance with Federal, State, and local law.

_____ IV. I understand and agree that a parent or legal guardian must be present on-site for the duration of each session. If a parent or legal guardian cannot not be present, the session may be subject to the late cancellation fee in the Attendance Policy,

_____ V. I understand that all service payments are due at the time of service, and that some therapy services may not be covered by my insurance plan. Therapy InSync, LLC will alert me as soon as possible about any portions of therapy which are not covered, and I understand that payment is due immediately upon receipt of that information and that it is my responsibility as the parent or guardian for paying for those uncovered services.

By signing this document, I agree to the above statements and agree to assume all risks associated with treatment at Therapy InSync LLC. I agree to release Therapy InSync, LLC and its members and managers from any liability for services rendered to the above-named child to the fullest extent permitted by law.

_____ _____

Parent/Guardian Signature Date

704 N. Main St. Newcastle, OK, 73065
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