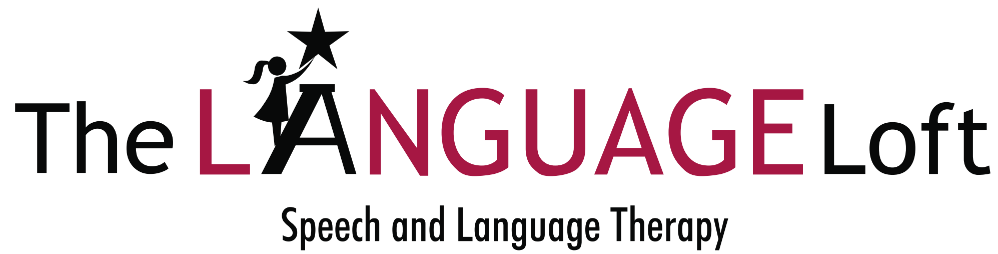

CONSENT FOR TREATMENT OF MINORS

Child's Name: ____ Date of Birth: __________

This is to certify that the information on the intake forms is accurate to the best of my knowledge. I give permission to ***The Language Loft*** to provide treatment to my child and to bill Medicaid for services rendered (if applicable). I verify that all legal guardians are aware of and give consent for this treatment.

____ _____________________

Printed Name of Parent or Guardian Relationship to Child

____ _____________________

Signature of Parent or Guardian Date

The Language Loft | 9470 Corkscrew Palms Circle, Suite 102 | Estero, FL 33928
Phone: 239-400-4221 | Fax: 239-567-5780