Consent to Treat

1. I ____________________ (patient name or authorized representative) give permission for Rainier Speech Therapy, LLC to provide medical treatment.

2. I allow Rainier Speech Therapy, LLC to file for insurance benefits to pay for the care I receive.

   I understand that:
   - Rainier Speech Therapy, LLC will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

____

Patient Printed Name

____ ______________

Patient Signature Date

____________________________ __________________ ______________

Signature of Consenting Party Relationship to Patient Date