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MULTIPLE SERVICE FORM

My child _____ does/does not receive other therapy services.

Type of Service:

Speech Therapy _____

Physical Therapy _____

Feeding/Swallowing _____

Location/Practice where seen: _____

_____

_____

How frequent are the sessions:

_____ times per week

_____ times bi-weekly

_____ times per month

I understand that services in addition to those received at Capital Kids Therapies may effect my overall insurance benefits. I will inform Capital Kids Therapies if therapy services change.

_____ _____

Signature Date