Speech Inspiration, PLLC

Authorization for Speech-Language Treatment

I hereby voluntarily consent to such speech and language treatment, including any screening, diagnostic testing and/or therapy to be performed on

_____(Print Patient Name)

that the Speech-Language Pathologists believe are necessary for the care of the patient.

I hereby state that I have the legal right to consent to the speech and language treatment of the patient listed herein. In the course of treatment, I understand and acknowledge that no warranty or guarantee will be made as to the results of treatment.

I acknowledged that administrative data, demographic information and other health information describing patient care, services and outcomes are collected and used for operations, research, governmental and non-governmental reporting, in comparisons with other speech - language providers. In some instances, performance data is aggregated and reported by Speech Language Pathologist. In every instance, the confidentiality of the patient and Speech Language Pathologist is maintained. Strict policies exist and are enforced by Speech Inspiration, P. LLC to ensure that the confidentiality and privacy of patient information is maintained.

I acknowledge and understand that each Speech Language Pathologist providing services at Speech Inspiration, PLLC, including those Speech Language Pathologist s who may be called upon to provide care either directly (as consultants), or indirectly through professional services are independent contractors who are self -- employed in are not the agents, servants or employees of Speech Inspiration, PLLC. I further agree that Speech Inspiration, PLLC is not responsible for the judgment or conduct of any of the Speech Language Pathologists.

I consent to the taking of photographs or films related to the care, treatment and services provided or other internal purposes, such as performance improvement or education, and understand that such photographs or films may be made part of the speech and language record.

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This authorization is effective from_____ (date) and continues until I cancel it as noted above or the expiration of two years from the date of my signature. The authorization covers any Speech and language treatment that are created after this authorization is signed.

___I have had the opportunity to read this form and ask questions about it.

_____ _____

Patient/Parent/Guardian Signature[1] **Date**

_____

Patient/Parent/Guardian Printed Name[2]

_____ _____

Street Address **Phone (Home)**

_____ _____

City, State, Zip **Phone (Work)**

[1] Signature of the person legally authorized to sign for patient
[2] Name of the person legally authorized to sign for patient