



CONSENT TO EVALUATE, SCREEN, AND/OR PROVIDE THERAPY SERVICES

Patient Name: _____ Date of Birth: _____

Primary Insurance Carrier (if applicable): _____ Policy # _____

Account Holder SSN/DBN #: _____

I consent to evaluation, screening, and/or treatment by a therapist at Uplift Speech Therapy Services. Treatment is based upon the findings of the evaluation and the recommendations of the responsible Speech-Language Pathologist.

I understand that services will be provided by a Colorado licensed Speech-Language Pathologist and certified by the American Speech-Language Hearing Association (ASHA) or Clinical Fellows under the direct supervision of an ASHA certified Speech-Language Pathologist. I understand that services will be rendered either in my home or at the office location, at the discretion of the provider.

Printed Name of Patient

Signature

Date