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

Child's Name: ______________________ Date of Birth: ________________

Parent Name(s): ____

Primary Insurance Carrier (if applicable): ________________ Policy # _______________

Account Holder SSN/DBN #: ____

I consent to evaluation, screening, and/or treatment, for my child ____________, 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/Parent Relationship to Patient

________________________________ ________________________________
Signature Date