



Ann Arbor
Speech & Language
Therapy Center, LLC

INFORMED CONSENT FOR SPEECH-LANGUAGE THERAPY SERVICES

Client Name _____ Date of Birth ____ / ____ / ____

Address _____
Street City State Zip

Parent/Legal Guardian

Name _____ Relationship to child _____

Address _____
Street City State Zip

Email _____ Phone _____

Parent/Legal Guardian

Name _____ Relationship to child _____

Address _____
Street City State Zip

Email _____ Phone _____

I, _____, the parent/guardian of _____,
(please print) (please print)
hereby request and consent to Ann Arbor Speech & Language Therapy Center, LLC providing treatment and care as prescribed by a physician and/or recommended by a Speech-Language Pathologist.

Please initial each item below:

____ For minor children, I acknowledge and agree that a parent/legal guardian or trusted adult must be in the home or waiting area of the office during each treatment session.

____ I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

____ I consent and authorize Ann Arbor Speech & Language Therapy Center, LLC to administer treatment under the direction and supervision of a licensed and certified Speech-Language Pathologist.

____ I understand that by signing this form, I am legally establishing a provider and client relationship.

Signature (parent/legal guardian)

Date