PRECISION THERAPY, LLC
Consent for Treatment
Phone: (315) 889-1690
Email: precisiontherapyllc@gmail.com

OFFICE USE ONLY	
ID	
DATE	
OTHER	

CONSENT FOR TREATMENT

I _____, hereby authorize and direct evaluation and/or treatment of
PATIENT/CAREGIVER/RESPONSIBLE PARTY
the name patient under the direction and supervision of the certified speech language pathologists of **Precision Therapy, LCC**

I understand I can ask any questions of my/my child's therapist at any time during the evaluation and treatment process. I understand that my/my child's therapist is best suited to provide an explanation of goals, treatment modalities and rationale of therapy.

I acknowledge and understand consistent attendance and family carryover are critical components in ensuring progress and understand that the benefits of therapy vary by individual. I understand therapy is based upon scientific principles and evidence based practice; however, there is no guarantee that speech therapy will improve my/my child's condition or status.

For children, I understand that a parent/caregiver must remain present in the office area during each evaluation/treatment session.

I have carefully read and understand the outlined consent form and agree to the terms as written above.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE