A Speech Connection Clinic

A SPEECH CONNECTION CLINIC, PLLC

CONSENT FOR TESTING/TREATMENT

I_____ consent to myself/my child being tested and treated, if applicable, at A Speech Connection Clinic on this month of _____, the_____, 20__.

DISCHARGE CRITERIA

A client may be discharged when the client has mastered all goals, an evaluation reveals services are no longer warranted or if there is a lack of progress after a variety of techniques have been exhausted.

PAYMENT INFORMATION

I understand that payment is due when services are rendered. If filing with insurance, a co-payment must be given before each treatment service. Please understand that your insurance coverage is an agreement between you and your insurance company. Payment of your account is your responsibility. If we have not received payment 60 days after a claim has been submitted, we will ask you to follow up on the reason for the delay. We do not have the office staff to continue to call on each claim we file. If you need additional information from us, please call our office and we will be glad to assist you.

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Signature