Back Bay Speech Therapy

Specializing in Speech, Language, Feeding, and Literacy Needs of Children

CONSENT FORM

I, ______________________, authorize the evaluation and treatment of my child, ________________, by Back Bay Speech Therapy Inc.

_________________________________ _____________

Parent Signature Date

I,_________________________________, authorize Back Bay Speech Therapy Inc. to contact my child, _______________________'s, pediatrician regarding any information that is deemed relevant to his/her plan of care. I also authorize the release of any medical or other information necessary to process insurance claims related to speech therapy services provided by Back Bay Speech Therapy Inc.

I authorize the payment of medical benefits to Back Bay Speech Therapy Inc for speech therapy services provided to my child, __________________________________.

_________________________________ _____________

Insurance Holder's Signature Date

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Insurance Holder's Name Printed

I have been given a copy of Back Bay Speech Therapy Inc.'s Notice of Privacy Practices, Financial Policy, and Attendance Policy. I have read and understand the policies and will keep them for my records. I understand the attendance/ cancelation policy and the risks of not adhering to it.

_________________________________ _____________

Parent Signature Date

I, _________________________________, authorize Back Bay Speech Therapy to contact and discuss my child's progress and therapy plan with any teachers/therapists at ______________________.

I understand that I have the right to revoke this authorization at any time and that I have the right to request a copy of this authorization for my records.

_________________________________ _____________

Parent Signature Date

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