SPEECH SUPERSTARS
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Informed Consent for Speech Language Therapy

______________________________________ _______________________________
Patient Name DOB

I hereby request and consent to Speech Superstars, to perform treatment and care for my child as prescribed by a physician and/or recommended by a Speech Language Pathologist.

1. I consent and authorize Speech Superstars to administer treatment under the direction and supervision of a certified and licensed Speech Language Pathologist. In addition:
   - I have seen and agree with the treatment goals and therapy plan.
   - I agree to attend scheduled therapy sessions (see attendance policy).
   - I agree to participate in my child's treatment as appropriate.
   - I agree to help my child carry over the skills learned in therapy at home.
2. I acknowledge and agree that a parent or legal guardian must be present during each treatment session in the office (either in the waiting room or in the therapy room with my child).
3. I understand that all therapy and evaluative service payments are due at the time of service, and that evaluations and therapy services are private pay. I understand that payment is due immediately upon receipt of services. I understand I may contact my own insurance company to check if Speech and Language services are covered under my own policy. I also understand I may request a bill of therapy services to be provided by the Speech Language Pathologist, and I understand I will be the one to submit this bill directly to my own insurance company.

By signing this document, I agree to the above statements and I agree to hold Speech Superstars harmless for claims or damages in connection with treatment. This is a contract between myself and Speech Superstars and I also understand that this is also a release of potential liability.

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Parent Signature Date