Permission to Screen/Evaluate/Treat

The following gives permission for Speech Solutions, Inc., including their speech-language pathologists and assistants, to screen and execute diagnostic measures (in the form of informal testing, standardized evaluations, clinical observation, language samples, etc.) to the undersigned client for the purposes of the diagnosis and subsequent treatment of speech and/or language deficits/delays. By signing below, the client (if 18 years of age or older), parent or guardian authorizes Speech Solutions, Inc. to screen, evaluate, and treat the client named below. Treatment is contingent upon the results of the evaluation and the impending recommendation of the responsible speech-language pathologist. Also, by signing this form, I give Speech Solutions, Inc. permission to file any and all insurance/Medicaid/NC Health Choice for payment of services rendered and to contact my child's doctor for authorization/concerns regarding the child's speech and language. I hereby authorize Speech Solutions, Inc. to release information acquired in the course of my evaluation and treatment. I hereby assign payment directly to Speech Solutions, Inc. for any services provided by our agency. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

_____
Client Name

_____ _____
Signature of client, parent, guardian Date

This form does not go out of date.

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