Speech Therapy Plus, pllc.
1421 FM 359, Suite H
Richmond, TX 77406
Phone: (281)-232-1900
Fax: (281)-232-1939

General Consent of Treatment

I have the legal right to authorize Speech Therapy Plus to provide speech therapy evaluations and treatment services because I am the legal parent/guardian of _____(patient) and voluntarily give consent to Speech Therapy Plus to provide these services as long as the therapist/patient relationship exists or until I withdraw my consent. _____ (Please initial)

Consent for Consultation Services

I authorize Speech Therapy Plus, PLLC., it's provider(s) and/or other designated office staff to share and consult with other providers (such as PCP, specialist doctors, and other speech therapists) in order to allow and promote the continuity of care for _____ (patient). _____ (Please initial)

Observation Consent

I authorize and give consent for _____ (patient), to receive treatment under the observation of a student either currently enrolled in a Speech Pathology curriculum program or one considering a Speech Pathology career. _____ (Please initial)

Consent for Email, Voicemail, and Text Notifications

As a service to our patients, Speech Therapy Plus may need to reach out to you via phone call, text, or email regarding an appointment or other speech therapy related items. At times it may require us to leave a message. The message may include protected health information. By initialing this notice, you consent to receiving such calls/ texts /emails at the phone number or email address you have provided to us. _____ **(Please initial)**

Email address: _____

Phone number for VOICE MAIL: _____

Phone number to TEXT: _____

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Consent for Release of Information

I authorize Speech Therapy Plus, pllc., it's provider(s), and/or other designated office staff, to release and obtain clinical information for _____ (patient) as it relates to the treatment, authorization for treatment, and for the purposes of insurance reimbursement. I understand this information may be shared with insurance companies, physicians' offices, and/or other required medical/educational offices as it relates to the treatment of this patient. If you have someone that you want your child's information shared with, please list the name(s), relationship to the child, and phone number of that person(s) here:

_____

_____

_____ (please initial).

I have read each of the above statements and I understand its contents. I understand I have had an opportunity to ask questions regarding any of these policies before providing consent. Therefore, I hereby agree and consent to all these statements and policies of Speech Therapy Plus.

_____ **(please initial)**

Patient Name: _____ Date of Birth: _____

_____ _____
Name of Parent/Guardian Relationship to Patient

_____ _____
Signature of Parent/Guardian Date