SUBSTITUTE RELEASE

Due to the scheduling needs of the therapists, there may be occasions when a substitute clinician will see the client. The consistency of therapy is extremely important to the client’s progress. Please let us know if we may accommodate your child by signing below and agreeing to the substitute therapist.

Agree__________________________  Do Not Agree______________________________

_____________________________________
Client/Parent/Guardian Signature

_____________________________________
Date

OBSERVATION RELEASE

Speech therapists, within the company, may be asked to observe the client to assist with the diagnosis and treatment plan. This release form permits these clinicians permission to observe.

Agree__________________________  Do Not Agree______________________________

_____________________________________
Client/Parent/Guardian Signature

_____________________________________
Date

PAYMENT/CANCELLATION POLICY

I have received a copy and understand the terms of the payment and cancellation policy.

_____________________________________
Client/Parent/Guardian Signature  Date