Pediatric and Adolescent Speech Therapy Associates

51 North Main Street

West Hartford, Connecticut 06107

 (860) 523-9790

# Consent for Treatment

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to Pediatric and Adolescent Speech Therapy Associates to provide evaluation and therapeutic services as deemed necessary by the treating clinician.

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Parent Signature Date

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Clinician Signature