



General Consent to Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended therapy to be used. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment of any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary evaluations and recommended therapy. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to therapy at the designated treatment location. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your therapist about the purpose, potential risks and benefits of any therapy offered to you. If you have any concerns regarding any evaluation or treatment recommended by your therapist, we encourage you to ask questions.

I voluntarily request a Speech Language Pathologist, Occupational Therapist, Registered Dietitian, Physical Therapist, Behavioral Analyst and other health care providers or the designees as deemed necessary, to perform reasonable and necessary evaluations and therapy for the condition, which has brought me to seek care. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian: _____

Date: _____