**Consent to Treat**

(Please Print Information)

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient)**

**birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby consent to any treatment deemed necessary by the Speech Therapist at Premier Speech Therapy, LLC.**

**Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent or Legal Guardian if under 18**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of patient if over 18 years of age**