Kid's Communication Connection
Speech & Language Therapy

Treatment Authorization

I agree to allow Kid's Communication Connection to provide speech-language pathology services for myself or my child. In addition:

- ☐ I have seen and agree with the treatment goals and therapy plan.
- ☐ I agree to attend scheduled therapy sessions.
- ☐ I agree to participate in my child's/loved one's treatment, as appropriate.
- ☐ I understand that my child/loved one may be given work to do at home. I agree to help my child/loved one do this work to help with treatment goals.

______________________________	______________________________
Print Patient's Name	Date
______________________________	______________________________
Patient or Parent/Guardian Signature	Relationship to Patient