



## Treatment Authorization

I agree to allow Therapy Corps, PLLC, to provide speech-language pathology services for my child or myself. In addition:

- I have seen and agree with the treatment goals and therapy plan.
- I agree to attend scheduled therapy sessions (see attendance policy).
- 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.
- I give permission for students from local universities who need observation hours to observe my child in therapy. I understand that they will not be providing any direct therapy to my child.

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Print Patient's Name

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Date

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Patient or Parent/Guardian Signature

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Relationship to Patient