24 W. Shadbolt, Lake Orion, MI 48362 • (248) 985-3742 • info@oaklandspeechandlanguage.com

Consent to Treatment

I desire that my child (or another child for whom I have legal responsibility, in each case, the "Patient"), receive diagnosis, treatment, and/or care by Oakland Speech and Language, LLC, a Michigan professional limited liability company, including its therapists (the "Provider"), falling within the scope of a speech-language pathology practice, defined by the American Speech-Language-Hearing Association. I consent to such evaluation, diagnosis, treatment, and care. I understand and acknowledge that no guarantee has been made to me, with respect to the outcome of such diagnosis, treatment, and/or care.

I acknowledge that I have read and understood this Consent to Treatment. If I am signing this Consent to Treatment on behalf of a child, I represent that I have the legal authorization to do so.

_____ Date: _____
Signature

_____
Print Name

_____ _____
Print Name of Patient (Child) Child's date of birth

_____
Your Relationship to the Patient (Child)