Joseph Falkner
MST/CCC-SLP
Speech Language Pathologist

First Last Name, Joseph Falkner, MST/CCC-SLP
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OFFICE USE ONLY	
ID	
DATE	
OTHER	

Informed Consent Form

I, _____, the client/parent/legal guardian of _____, hereby request and consent Joseph Falkner, MST/CCC-SLP to perform evaluation and treatment services, as needed, for myself/my child as prescribed by a physician and/or recommended by a speech-language pathologist.

By signing this form, you agree that you understand and are informed that, as in the practice of medicine, speech language may have some risks. You agree that you understand that you have the right to ask about these risks and have any questions answered about you/your child's condition, prior to, or at any time during, treatment.

Our first few sessions will involve an evaluation of your needs. After the evaluation has been completed, an evaluation report will be completed and a treatment plan will be proposed based on the results of the evaluation. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. All therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you find another therapist.

By signing this form, you agree that you have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist. You also acknowledge that no guarantees have been made about the results of treatment. Finally, by signing this form you give consent to Joseph Falkner, MST/CCC-SLP to provide evaluation and treatment as needed.

_____ _____

Signature of Client/Parent/Legal Guardian Date