CONSENT TO TREATMENT

SZ Therapies conducts consultations, workshops, parent training groups, screenings, evaluations and treatment for speech, language, and related disabilities. By reading and signing this form you are agreeing to allow SZ Therapies to engage in serving you or your child through the below listed services and conditions.

I, the undersigned, consent to the following treatment practices:

- Administration and performance of all consultation, screening, evaluation, and therapy procedures as they relate to my/my child's needs.
- Administration of standardized and non-standardized testing as deemed necessary.
- Performance of all treatment practices may occur at SZ Therapies main or satellite locations.
- Discontinuation of services may be made at any time based on the judgment of the assigned Speech Language Pathologist.

I, the undersigned, understand and acknowledge the following conditions upon initiating treatment practices with SZ Therapies:

- This form is to be presented and signed before initiating screening, evaluation, and therapy procedures.
- My signed consent is valid for the duration of the treatment practices that SZ Therapies provides.
- I acknowledge that SZ therapies will use and disclose my personal information for the purposes of treatment, payment, insurance verifications, and business operations as described in the HIPAA Privacy Statement Form or with my additional signed consent.
- Digital/scanned and photocopied versions of this form are as valid as the original.
- Revocation of consent must be presented to SZ Therapies in writing.
- I acknowledge that SZ Therapies has provided me with the HIPAA Privacy Statement and I am aware of the privacy practices identified within including procedures for questioning practices and to file a complaint.

I certify that I have read and understand the above listed services and conditions. By signing below I fully and voluntarily consent to the statements made in this form.

_____ _____ _____

Patient Signature (or patient representative) Date Relationship to Patient

Scott Zischke MA, CCC-SLP
SZ Therapies LLC
9233 Park Meadows Drive
Suite #225
Lone Tree, CO 80124
303-625-4092

TO REVOKE CONSENT TO TREATMENT PRACTICES, I am providing my signature below with the understanding that this will be recorded in my/my child's file, all services will be terminated, and any unpaid services will be due for immediate payment.

_____

Signature Date