DYSPHAGIA
Voice Therapeutics

Dysphagia-Voice-Therapeutics PLLC
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Fax: (910) 668-1340
tamralowry@dysphagiavoice.com

Consent for Services

☐ I authorize Dysphagia & Voice Therapeutics PLLC to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by notifying Dysphagia & Voice Therapeutics PLLC in writing. In addition, Dysphagia & Voice Therapeutics PLLC may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent regarding Dysphagia & Voice Therapeutics PLLC rendering evaluation and therapy services to the client named below.

_____ _____
Print Name of Client Date

_____
Client Date of Birth

_____ _____
Signature of Client or Legal Representative Relationship to Client