



**Bonnie Vaillancourt M.S. CCC-SLP**

Speech Language Pathologist

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**AAC • Consultation • Diagnostics • Therapy**

### **Informed Consent To Provide Speech and Language Services**

I, \_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_, hereby request and consent to Simplified Speech Solutions, LLC providing evaluation and treatment as prescribed by a physician and/or recommended by a speech language pathologist.

For minor children, I acknowledge and agree that a parent or legal guardian must be present in the waiting area of the office for clinic based therapy during each treatment session.

I hereby carefully read and fully understand this Informed Consent for and have had the opportunity to discuss it with the treating therapist.

I consent and authorize Simplified Speech Solutions, LLC to administer evaluation and treatment under the direction and supervision of a certified Speech-Language Pathologist.

\_\_\_\_\_

Signature of parent/legal guardian

\_\_\_\_\_

Date

