firstrowe
speech & feeding therapy center

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Treatment Authorization

I agree to allow FirstRowe Speech Pathology, P.C., to provide speech-language pathology services for my child. In addition:

- ☐ I have seen and agree with the treatment goals and therapy plan.
- ☐ I agree to attend scheduled therapy sessions (see attendance policy).
- ☐ I agree to participate in my child's/loved one's treatment, as appropriate.
- ☐ I understand that my child/loved one may be given work to do at home. I agree to help my child/loved one do this work to help with treatment goals.

Print Patient's Name	Date
Patient or Parent/Guardian Signature	Relationship to Patient