**Allegretto Therapy Services, LLC**

**694 Wharton Blvd**

**Exton, Pa. 19341**

**Phone: (610)-715-2702**

**INFORMED CONSENT FOR SPEECH THERAPY**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby request and consent to Allegretto Therapy Services, LLC to perform treatment and care for my child as prescribed by a physician and/or recommended by an speech therapist.

I fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist. I consent and authorize Allegretto Therapy Services to administer treatment under the direction and supervision of a certified speech therapist.

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Signature of Parent/ Legal Guardian

Date: