Consent to Treat and Financial Responsibility

Empowered Speech Pathology, LLC, 1820 N Alston St, Suite C, Foley AL 36535

Consent to Treat and Financial Responsibility

I consent to receive evaluation and treatment from **Empowered Speech Pathology, LLC** for speech-language pathology services. I understand that treatment may include assessments, therapy, consultations, and other necessary services.

I acknowledge that I am financially responsible for all services received. I understand that payment is due at the time of service unless other arrangements have been made. I authorize **Empowered Speech Pathology, LLC** to bill my insurance and release necessary information for claims processing. I understand that I am responsible for any portion not covered by insurance.

Patient/Guardian Name: _____
Signature: _____
Date: _____

If signed by a legal representative:

Representative Name: _____
Relationship to Patient: _____