Auditory-Verbal Center, Inc.

CONSENT TO TREAT

Client Name: _____

Date of Birth: _____/_____/_____

By signing this document, I, the undersigned client (or authorized representative), consent to and authorize the Auditory-Verbal Center, Inc. to give me medical treatment. As ordered by the healthcare professional assigned to my care, I consent and authorize the performance of any treatments, examinations, medical services, and diagnostic procedures

By signing this document, I am also allowing the Auditory-Verbal Center, Inc. to file for insurance benefits to pay for the care I receive. I understand that the Auditory-Verbal Center, Inc. will have to send my medical record information to my insurance company and I must pay for my share of the costs if insurance does not pay or if I do not have insurance.

By signing this document, I understand that I have the right to refuse any procedure or treatment and I also have the right to discuss all medical treatments witih my provider.

_____ _____

Client Signature Date

_____ _____ _____

Name of Parent/Legal Guardian (please print) Relationship to Client Date
(if client is under 18 years of age)

_____ _____ _____

Signature of Parent/Legal Guardian Relationship to Client Date
(if client is under 18 years of age)