

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Authorization for Services**

* I authorize Longwood Speech, Hearing, & Learning Services (SHLS) to provide speech-language and/or audiology services to myself or my child/dependent. I also understand and consent to the following:
* I understand that services maybe provided by a graduate of undergraduate student clinician under the supervision of a clinical supervisor, who is licensed by the Commonwealth of Virginia and Certified by the American Speech-Language-Hearing Association (ASHA).
* I have read the Notice of Privacy Practices(you may request a copy)
* I understand that services maybe observed by individuals engaged in student training.
* I have read Longwood University Acknowledgement of Risk and Release.
* I understand that all evaluation and treatment procedures will be explained to me.
* I assume responsibility for my and/or my child’s/dependent’s compliance with all instructions and directions of Longwood University staff while I or my child/dependent receive(s) services at SHLS.
* I understand that this is a teaching facility and that SHLS will video speech-language sessions for clinical training and educational purposes only.
* Audiology services are not videotaped unless special permission is requested by SHLS prior to services.
* Photography maybe used by SHLS for Educational/Training purposes, Official University Publications, Marketing Materials or Camps (which will be shared with other camp participants). There is a separate release for Photography of services.
* I understand that SHLS, in conjunction with Longwood University Communication Sciences and Disorders Program, have a commitment to research and development of knowledge and services related to speech-language pathology and audiology. I understand that I may be contacted for participation in a research project. My participation is entirely voluntary and will not affect my participation in SHLS activities.
* I understand that my child or dependent will not receive services at SHLS unless he/she is accompanied by a caretaker who is over the age of 16. **It is our policy that the caretaker must remain in the building at all times while services are being provided.**

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 **Printed Name of Client/Parent/Guardian Signature of Client/Parent/Guardian**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**