PERMISSION TO TEST AND TREAT

I, ____________________________, authorize and grant permission for University of Nebraska at Kearney RiteCare Clinic faculty and students to administer tests and provide those clinical services deemed necessary for the purposes of identifying and treating speech, language, and/or other communication disabilities. This may include one-on-one private interactions. Faculty supervisors will be present in the building during all interactions and will have camera access to individual therapy rooms.

The University of Nebraska at Kearney RiteCare Clinic has several purposes: to assess and treat persons with speech, language, swallowing, and hearing problems, to offer ongoing instructional program for students in Speech Pathology and Audiology, and to continue investigations on the nature of speech, language, swallowing, and hearing problems.

In consideration of these clinical services being provided to my child, me, or other family member, I further agree to the following UNK RiteCare Clinic activities:

1. to allow the Clinic to exchange information with other professionals (physicians, dentists, teachers, etc.) through letters, reports, and conferences as designated on the attached Authorization form.

2. to permit other professionals and students in Speech Pathology and Audiology to observe the testing and clinical procedures provided.

3. to allow the Clinic to make audio and video tape recordings, motion pictures, and still photographs with the understanding that these may be replayed or shown anonymously for educational purposes only.

4. to permit participation in research projects on speech, language, and hearing problems when the specific purposes and procedures of the research have been explained to me and the appropriate consent forms have been signed, and to permit anonymous publication of the results.

Financial Agreement Form
I understand that I am responsible for all charges associated with any of the services provided and that payment is due at the time of service for evaluations and monthly for ongoing clinical services. In the event that I do not submit payment within 30 days of billing, services will be suspended until all accounts are satisfied.

Name of client (printed) ____________________________________________

Signature of Client or Parent/Legal Guardian ____________________________________________

Date of Signature ___________________________