teamspeechorg@gmail.com
phone 720-317-6308

Client Contact Disclosure and Consent for In-Person Services

Speech Therapist: Rebecca Sobolevsky; MS; CCC-SLP

_____ I authorize the therapist listed above to meet the client named below **for recurring, in-person therapy services**. I understand that, while the therapist will follow Center for Disease Control (CDC) precautions and guidelines in order to decrease the spread of viruses, the therapist cannot control or be held responsible for any spread of virus to the client or client's associates.

> ____ I agree to inform the therapist listed above if any person in my household (or other in home therapist/visitor/individual) displays symptoms of COVID19 as listed by the CDC (shortness of breath, difficulty breathing, fever, chills, muscle pain, sore throat, new loss of taste or smell) within a 14 day window of in person treatment. Or if someone in my household has been exposed to an individual known to have tested positive for COVID19 via contact tracing in the past 14 days.

_____ I may request that services be rendered via **telehealth.** I understand that the conditions of telehealth services depend on payment and that the client (or the client's caregivers) are responsible for setting up and maintaining technology at the originating (client) site.

_____ I may request that services be rendered via a **combination of telehealth and in person** as agreed upon between myself and my therapist.

____ I recognize, agree, and understand that I have the right to refuse treatment or terminate services at any time by notifying Team Speech in writing. In addition, Team Speech may terminate services by notifying me in writing.

Client Name	
Client Date of Birth	
Date	
Signature of Client or Legal Representative	
Relationship to Client	