Grays Peak Speech Services, LLC
Jennifer Gray, M.S., CCCC-SLP
www.grayspeaktherapy.com
720-514-9216

Request for Diagnostic Evaluation and/or Therapy Services

Please read, sign, and bring with you to your first session or evaluation

Name:_____ **DOB**:_____

My signature on this form indicates I understand and agree to the following conditions.

I grant my permission to Grays Peak Speech Services, LLC to provide appropriate services to the above named client. I understand that I have the right to ask questions or terminate services at any time.

I grant Grays Peak Speech Services, LLC permission to use my information for the sole purpose of clinical assessment, diagnosis, and treatment of speech, language, oral-motor, and feeding concerns, delays, and disorders. Confidentiality will be maintained.

Permission granted: **YES**: _____ **NO**: _____

Client/Parent Signature: _____ **Date**: _____

Therapist: _____ **Date**: _____