Communication Dynamics

Pediatric Speech Therapy Services

PARENTAL CONSENT FOR TRANSFERAL OF SERVICES

Your child's medical insurance carrier has advised our office that your child has an open authorization for speech therapy services with another facility. This form must be completed and signed to transfer services to Communication Dynamics. Before completing this form, as a courtesy, please inform the former therapist that you will be transferring services.

My signature below signifies to all parties involved with my child's speech and language treatment that I would like to have services transferred to Communication Dynamics.

Reason for Change: _____

_____

Child's Name_____ DOB_____

Parent's Name (Print) _____

Parent's Signature_____ Date_____

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