BLUEGRASS PEDIATRIC THERAPIES

Permission to Screen

Child's Name:_____ Child's DOB:_____

By signing this form, I am granting permission for Bluegrass Pediatric Therapies to screen my child for Speech and/or Occupational Therapy. I understand that by signing this form, my child is not guaranteed to receive services and that no insurance companies will be billed and/or out of pocket expenses required for screening services provided on this date.

_____
Printed name of Legal Guardian

_____ _____
Signature of Legal Guardian Date

Phone number:_____

Email:_____

Bluegrass Pediatric Therapies
2150 Lexington Rd Suite A&B ● Richmond, Kentucky ● 40475
505 Shoppers Dr Suite C ● Winchester, Kentucky ● 40391
PHONE (859)353-5445 ● FAX (859)353-5601