



5890 Bethelview Rd Ste 10-160 Cumming, GA 30040  
Phone: 770-886-6204

### CONSENT FOR TREATMENT

I, \_\_\_\_\_ (caregiver's name), knowing that \_\_\_\_\_ (child's name) has a diagnosis requiring speech and/or occupational therapy treatment, voluntarily consent to such care for the aforementioned child by the therapist doing business for Building Bridges Therapy, Inc. as may be beneficial in the professional judgement of this child's therapist. I consent to care and treatment that falls within the scope of occupational/speech practice as defined by the State of Georgia. I understand that treatment will involve physical participation on the part of the patient which may involve risks of injury. I acknowledge that no guarantee has been made to me as the result of evaluation and/or treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian Relationship

Witness: \_\_\_\_\_

In my absence, I consent that \_\_\_\_\_ (child's name) may receive speech and/or occupational therapy under the care of :

\_\_\_\_\_  
(List all caregivers, teachers, daycare providers, etc. that may be present during therapy in your absence.)

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian Relationship

Witness: \_\_\_\_\_

**Building Bridges Therapy**  
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