Omni Therapy Solutions
Speech·Occupational·Physical
1053A Sparkleberry Lane Ext., Columbia, SC 29223
Phone: 803-567-3348 | fax: 803-728-3044

Permission to Administer Evaluation

Client's Name: _____ Date of Birth: _____
Last First Middle

I hereby give written permission for the above-named client to receive a comprehensive speech-language, occupational, or physical evaluation. I understand that a licensed therapist will administer the evaluation and the evaluation may consist of formal and informal measures to assess present levels of skills. I also understand that the results of the evaluation will be communicated to me in writing and verbally if requested with further recommendations. *Disclaimer: Although Omni Therapy Solutions (OTS) will be conducting the evaluation, we are not required to provide therapy if results indicate it is needed.*

_____ _____
Print Patient/Parent/Legal Guardian's Name Signature

_____ _____
Relationship to Client Date

Permission to receive therapy

Client's Name: _____ Date of Birth _____
Last First Middle

I hereby give permission for the above-named client to receive skilled therapy services through OTS, LLC. Therapy will be individualized to meet the client's needs based on the results of the evaluation. Therapy services will be performed by a licensed therapist or licensed assistant. I understand that I may terminate these services at any time by giving written notice to OTS, LLC. I further understand that I am responsible for full payment for services rendered.

_____ _____
Print Patient/Parent/Legal Guardian's Name Signature

_____ _____
Relationship to Client Date