



**Policy Consent Agreement**

I, \_\_\_\_\_, \_\_\_\_\_'s caregiver have read, understand, and agree to abide by the following policies set forth by S.M.I.L.E.S., Speech-Language Pathology & Education, Inc:

- Payment Policy
- Cancellation Policy
- Session Policy
- Late Return Policy
- HIPPA Policy
- Disclosure Form
- Video Consent Form

I also understand that any of these policies may be updated at any time and that I will be provided notice, when changes are made.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Caregiver's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date