REQUEST FOR DIAGNOSTIC SERVICES

I REQUEST THAT ___________________________________________
Receive diagnostic services at the MU Speech and Hearing Clinic at the
University of Missouri.

I understand that the service is provided by graduate student clinicians
working under the careful supervision of certified, licensed faculty.

I understand that there is a fee for services and that I am responsible for the
payment of those fees.

I understand that the evaluation may be observed by those in the
training program and that reports may be read by authorized persons
in the program. I understand that the evaluation may be audio and/or
video recorded and that these recordings may be used in training
sessions. Confidentiality will be maintained.

I understand that standard test equipment and procedures will be used in
evaluating the individual and gathering the diagnostic data; and that I/we
may need to return at a later time to discuss the findings and
recommendations.

__________________________________________  __________
Signature      Date

__________________________________________
Relationship to Client