RECEIPT OF STUDIO POLICIES FORM

VELARDE VOICE, LLC
RACHEL VELARDE, MM, MM, SVS CLINICAL FELLO
6801 E. LOMA LAND DR., SCOTTSDALE, AZ 85257

Today's date_____

I, the undersigned patient/client, have received a Studio Policies for SVS Habilitation Statement from VELARDE VOICE, LLC/Rachel Velarde, MM, MM, SVS Clinical Fellow. I understand and agree to abide by all stated policies.

_____

Patient/client signature

_____

Patient/client printed name

_____

Responsible Party signature (if different from Patient/client)

_____

Responsible Party printed name