Davis Psychological Services Consulting, PLLC
CONSENT FOR TREATMENT-Child

I, ____, on behalf of my child,

____, authorize and request that

____, (Ph.D./L.C.S.W./L.M.H.C.) provide neuropsychological and/or psychological assessment, biopsychosocial assessment, treatment and/or psychotherapy or counseling which now or during the course of my child's care are advisable.

The frequency and type of treatment will be decided between all parties.

1 understand that the purpose of these procedures will be explained to us and be subject to my verbal agreement.

I understand that there is an expectation that my child will benefit from assessment/psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times my child may feel conflicted about receiving service as the process can sometimes be uncomfortable.

1 have read and fully understand this Consent for Treatment Form.

Date: _______ Patient Signature:

Date: Witness: