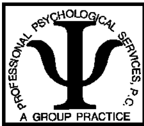

PROFESSIONAL PSYCHOLOGICAL SERVICES, P.C.

Consent for Treatment of Minor Dependent

RE:____BIRTHDATE:__________
LAST NAME, FIRST MIDDLE

I certify that I am the {father, mother, managing conservator, legal guardian (circle one)} of the above named child, I hereby give my authorization and informed consent for the above named child to receive psychological or therapeutic outpatient diagnostic and treatment services from the staff of Professional Psychological Services, PC. I further certify that I have full legal authority to authorize and consent to this evaluation and/or treatment.

Date:_________________________

Father: ____
(signature)
or

Mother:____
(signature)
or

Managing Conservator:____________________________________
(signature)
or

Legal Guardian:____
(signature)

Print Name:____

Address:____
____
____
____

600 West Campbell, Suite 2 ! Richardson, Texas 75080
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www.ProfessionalPsychologicalServices.com