Children's Psychological Services
www.childrenspsychologicalservices.com
Tel: 415-484-8479

Consent to Assess or Treat a Minor

Date: _____

Patient's Full/Legal Name: _____ Patient Date of Birth:_____

Name of Parent/Guardian #1:_____ Relationship: _____

Address:_____

Phone: _____ Email: _____ Parent #1 Date of Birth: _____

Name of Parent/Guardian #2:_____ Relationship: _____

Address:_____

Phone: _____ Email: _____Parent #2 Date of Birth: _____

I, _____, custodial parent/legal guardian of _____

age, _____, authorize Trishanjit (Trish) Singh, PsyD, of Children's Psychological Services, to assess and treat my child in this outpatient treatment setting. I agree to take part in the assessment and evaluation process as needed, and understand the format of the assessment may include any combination of the following: developmental history, medical history, treatment history, school history, behavioral observations in any setting, collateral with any professionals involved in my child's care, any diagnostic testing (i.e., cognitive, academic achievement, social/emotional, personality, executive functioning, receptive/expressive language, developmental, motor, sensory, adaptive, memory, attention/concentration, risk assessment), review of previous evaluations, parent feedback, and treatment recommendations. I agree to allow my child to be treated through individual therapy sessions, parent sessions, and/or conjoint family sessions.

Signature of Parent/Guardian #1: _____ Relationship: _____

Printed Name: _____ Date: _____

Signature of Parent/Guardian #2: _____ Relationship: _____

Printed Name: _____ Date: _____