CHILD AND ADOLESCENT CONSENT FOR TREATMENT

PATIENT: _____ DATE OF BIRTH: _____/_____/_____
(Last Name) (First) (Middle)

I certify that I am the (circle one) father / mother / legal guardian of the above named child/adolescent and that I do have legal custody of the above named child/adolescent. I hereby give my authorization and consent for the above name child/adolescent to receive outpatient assessment/therapy from _____.

DIVORCE/LEGAL SEPERATION COLLECTION POLICY

It is the policy of Breaking Free Services, Inc. that the parent/guardian bringing a child/adolescent to our office for treatment, is responsible for payment of services rendered at that time. If you have a financial arrangement for payment of the child/adolescent's medical care, either oral or written, with the child/adolescent's other parent or responsible party, you will be expected to pay for the child/adolescent's care at the time of service and arrange for your personal reimbursement with the other party. In the event of a true emergency, treatment will not be denied to your child/adolescent.

_____
(Print Parent/Legal Guardian's Name)

_____ / /
(Parent/Legal Guardian's Signature) (Date)

_____ / /
(Witness' Signature) (Date)