MARVELOUS MINDS
Dr. Kymberly F. Larson, Psy.D.
Pediatric and Adolescent Neuropsychologist
420 Pennsylvania Ave. Suite 101
Glen Ellyn, Il 60137
doclarson@marvelousminds.net

Consent to Treatment, Ages 11 and Younger

I acknowledge that I have received, have read, and understand the "Information for Clients" brochure and/or other information about the therapy or testing I am considering to for my child. I have had all my questions answered fully.

I attest that I have legal custody of this child and am able to consent to his/her mental health treatment. I hereby consent that my child_____ take part in the treatment by the psychologist named below. I understand that developing a treatment plan with this psychologist and regularly reviewing our work toward meeting the treatment goals are in my child's best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this psychologist.

I am aware that I may stop my child's treatment with this psychologist at any time. The only thing I will still be responsible for is paying for the services we have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment.

I know that I must call to cancel an appointment at least 48 hours (2 days) before the time of the appointment, or pay the agreed-upon fee.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments my child receives. I understand that if payment for the services I receive here is not made, the psychologist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____Signature of parent _____Date
_____Printed name

I, the psychologist, have discussed the issues above with the parent. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent for his/her child's treatment.

_____Signature of psychologist _____Date
Kymberly F. Larson, PsyD ❑ Copy given to parent ❑ Copy refused by parent
This is a strictly confidential patient medical record. Rediscloure or transfer is expressly prohibited by law.