REBECCA STIRITZ, PSY.D.

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Consent to Treatment of a Child/Minor

Name of child patient:_____

Rebecca Stiritz, Psy.D. and I have discussed my child's situation. I have been informed of the risks and benefits of different treatment choices. I have had the chance to discuss these issues, have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist (or another professional, if recommended) permission to begin this treatment.

_____ _____

Signature of Parent(s) Date

_____ _____

Signature of Dr. Rebecca Stiritz