

**Maria Schmid** B.A. M.Ed R.Psych

**Registered Psychologist**

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**CONSENT FOR TREATMENT**

I or We, \_\_\_\_\_, \_\_\_\_\_ consent to

Maria Schmid, Registered Psychologist providing psychological services to:

\_\_\_\_\_  
(name of minor / dependent adult) (date of birth dd/mm/yyyy)

\_\_\_\_\_  
(name of minor / dependent adult) (date of birth dd/mm/yyyy)

\_\_\_\_\_  
(name of minor / dependent adult) (date of birth dd/mm/yyyy)

\_\_\_\_\_  
(name of minor / dependent adult) (date of birth dd/mm/yyyy)

Please circle the appropriate marital situation (a,b,c,d or e):

- a) Biological parents residing together.  
(consent for treatment form can be signed by one biological parent)
- b) Biological parents not residing together – sole custody agreement.  
(consent for treatment form can be signed by parent with sole custody)
- c) Biological parents not residing together – joint custody agreement.  
(consent for treatment form must be signed by both biological parents)
- d) Biological parents not residing together – no current custody or separation agreement in place. (consent for treatment form must be signed by both biological parents)
- e) Other situation, please describe:

Contact Info:

Mother: \_\_\_\_\_  
(name)

Father: \_\_\_\_\_  
(name)

\_\_\_\_\_  
(primary phone number)

\_\_\_\_\_  
(primary phone number)

I confirm that the above is true and accurate:

\_\_\_\_\_  
(signature of mother)

\_\_\_\_\_  
(signature of father)

\_\_\_\_\_  
(date dd/mm/yyyy)

\_\_\_\_\_  
(date dd/mm/yyyy)

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(date dd/mm/yyyy)

\_\_\_\_\_  
(date dd/mm/yyyy)