CONSENT FOR PSYCHOLOGICAL AND COUNSELING SERVICES (CHILD)

CLIENT INFORMATION

Child's Name:

Date of Birth:

Address:

Phone:

I, _____ consent for my child:
Parent/Guardian Name

_____
Child's Name

to receive psychological and counseling services from Deerfield Counseling, LLC. All information pertaining to psychological and counseling services are confidential; however, administrative staff will participate in filing billing information. Administrative staff are held to confidential guidelines.

Services may include any of the following:

a) Clinical Interview
b) Psychological Testing
c) Counseling
d) Review of mental health, medical, psychiatric, legal, and school records
e) Consultation with school staff, attorneys, other mental health professionals
f) Interpretation and review of results
g) Participation in behavior planning, PCP's, IEP's, and 504 plans as necessary
h) Assisting with coordination of services as necessary

_____
Parent/Guardian Signature

_____
Date