Rodney E. Timbrook, Ph.D.
Health Service Provider in Psychology
Psychological Service Associates, Inc
3421 E State Blvd
Fort Wayne, Indiana 46805

Consent to Psychological Treatment of A Minor Child

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

I do hereby seek and consent for my child, (insert child's name)_____, to take part in the treatment provided by *Rodney E. Timbrook, Ph.D., HSPP.* I understand that developing a treatment plan with this psychotherapist for my child and regularly reviewing the work toward meeting the treatment goals are in my best interest and those of my child. I agree to play an active role in this process, as agreed upon by Dr. Timbrook and my child.

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

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

I know that I must call to cancel an appointment at least 48 hours before the time of my child's appointment. If I do not cancel or do not show up, I will be charged for that appointment.

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 my child receives here is not made, the psychotherapist may stop my child's treatment.

My signature below shows that I understand and agree with all of these statements and that I am the legal guardian of this child and legally able to consent for treatment.

_____ _____
Signature of patient's parent/legal guardian Date

_____ _____
Printed name Relationship to patient