Child/Adolescent Treatment Consent

I, _____,

give consent and authorization for

_____
(name of child/adolescent/client)

to receive clinical services from Kevin L. Fried, PhD.

I understand that I am responsible for the time set aside for me or for my family members and that a charge will be made for such scheduled appointments if they or I do not keep them unless I give 24 hours advance notice.

I have read this form and any questions I had have been fully addressed. I understand its contents and agree to its terms.

_____
Parent or Legal Guardian Signature

_____
Date