NeuroBehavioral Associates

Vincent P. Culotta, Ph.D., ABPN • Melissa Blackwell, Psy. D. • Kirk Griffith, Ph.D., MBA

DATE ______________________

CONSENT FOR TREATMENT OF A MINOR (if applicable)

As a custodial parent, I authorize NeuroBehavioral Associates to provide an evaluation and treatment of my minor child, ________________________. I also give permission for my child's primary therapist or primary care physician to consult with NeuroBehavioral Associates to insure quality care for my child.

I understand that all data interpretation, diagnosis, and report preparation are provided by a licensed psychologist. Psychological associates, supervised by a licensed psychologist, may administer standardized assessment measures.

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PATIENT (or Guardian if applicable)

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RETURNED CHECK CHARGE

All returned checks are subject to a $25.00 returned check charge. All payments must then be made in cash or by money order.

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PATIENT (or Guardian if applicable)