PSYCHOLOGICAL SERVICES FOR FAMILIES
410 North A Street
Oxnard, CA 93030
805-487-2244 Fax 805-487-2255

CONSENT FOR TREATMENT

I, _____,
*(PLEASE PRINT NAME: CLIENT **OR** PARENT/GUARDIAN)*

authorize and request PSFF, a California Licensed (Psychologist/Marriage & Family Therapist/Clinical Social Worker/Marriage & Family Therapist Intern/Associate Clinical Social Worker) to provide psychological examinations, treatment and/or diagnostic procedures which, now or during the course of my/my child's care as a client, are deemed advisable. The frequency and type of treatment will be decided between the therapist and me.

I understand that the purpose of such procedures will be explained to me and be subject to my verbal agreement.

I understand that, while there is an expectation that I/my child will benefit from psychotherapy, there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that I may feel conflicted about my/my child's therapy as the process, at times, can be uncomfortable.

I have read and fully understand this Consent for Treatment form.

Date: _____ **Signature:** _____
(Client or Parent/Guardian)

Date: _____ **Signature:** _____
(Client or Parent/Guardian)