PSYCHOLOGICAL CENTER
for Expert Evaluations, Inc.

Authorization for Treatment or Psychological Evaluation

Client Name: _____ DOB:_____

___ Individual Therapy

___ Group Therapy: (Type)_____

___ Family Therapy

___ Parenting Education

___ Psychological Evaluation: (Type)_____

___ Other_____

I, _____, an applicant for services of Psychological Center for Expert Evaluations, Inc. voluntarily consent to treatment.

OR

I, _____, acting as representative or guardian grant permission to Psychological Center for Expert Evaluations, Inc. to render treatment as deemed necessary for the above named applicant.

Consent for Treatment or Psychological Evaluation or treatment of a Minor Child

Please check one of the following:

___ The client is a child of two *married* individuals

___ The client is a child of two *never married* individuals:
____ with a parenting plan ___no parenting plan

___ The client is a child of two *divorced* individuals:
____ with a parenting plan ___no parenting plan

3307 Northlake Blvd., Suite 101, Palm Beach Gardens, FL 33403
P: 561-429-2140, F: 561-318-5896
drktolbert@ForensicPsychologicalCenter.com

___ The client is a child who is part of an **active** court ordered restraining order or injunction for protection against Domestic Violence

*<u>Please note</u>: *If there are any active parenting plans or court orders, it is the parent or legal guardian's responsibility to provide a copy to the respective clinician. Furthermore, it is the parent or legal guardian's responsibility to notify the Psychological Center for Expert Evaluations, Inc.of any changes in active court orders or changes to parenting plans.*

I hereby authorize Psychological Center for Expert Evaluations, Inc. professional staff to administer treatment or a psychological evaluation. I certify that I have been informed of the nature and purpose of this treatment, and have been informed that this consent can be revoked orally or in writing prior to, or anytime during the treatment period.

I have read and fully understand the above Consent. No guarantee or assurance has been made to me as to the results that may be obtained.

_____ If indicated, the client understands they will be seen by a student clinician under the supervision of Kristin Tolbert, PY8460. Your signature below indicates that this has been explained to you, and you have expressed your consent.

Client Signature: _____ Date:_____

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date:_____

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Attendance Policy

Please read the following rules regarding your services and attendance. If you have any questions or concerns after reading these rules, please speak with your therapist.

1. I understand that any appointment missed for any reason that is not rescheduled that same week is considered an absence. Two instances of tardiness over 15 minutes will result in one absence.

2. I understand that missing two consecutive therapy appointments or three absences total is grounds for discharge from therapy. If I must cancel the appointment due to an illness or emergency, I will contact the office as soon as possible. Appropriate documentation will be required for the session(s) missed.

3. I agree to call to cancel my appointments at least 48 hours in advance. If I do not call to cancel and do not attend therapy, this will be considered a "no-show."

4. I agree to notify the therapist at least two weeks in advance of vacations or extended leave of absence for the duration of my scheduled treatment sessions.

If you have read and understood the above rules regarding your services and attendance, please sign and date below as a sign of your agreement and full understanding of the rules regarding attendance.

_____ _____

Print Name Signature

_____

Date

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