The Therapeutic Center for Children and Families

Andrew Lustbader, MD
Preston Wiles, MD
Jill L. Barron, MD
Jill Vaughan, APRN
Deirdre Trevett, APRN
Adrienne Nash, APRN
Maryellen Pachler, APRN
Catherine Lewis, LCSW
Amy McQuaid, LCSW
Leslie Greenblatt, LCSW
Katherine Sullivan, LCSW

CONSENT FOR TREATMENT

Patient Name(s): _____

_____

_____

I am (we are) the sole legal guardian(s) for the patient(s) listed above and, by signing below, do hereby grant to the Diagnostic and Therapeutic Center and its providers my (our) medical permission and informed consent for the mental health evaluation and treatment for the patient(s) listed above:

Parent/Guardian Name (please print): _____
(if applicable)

Parent/Guardian Signature: _____ Date: _____
(if applicable)

Parent/Guardian Name (please print): _____
(if applicable)

Parent/Guardian Signature: _____ Date: _____
(if applicable)

Mental Health Provider: _____

Provider Signature: _____ Date: _____