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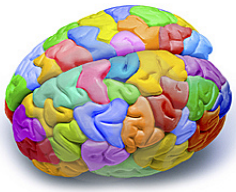

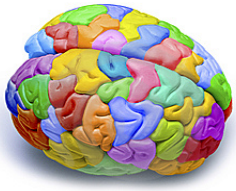

Consent for Treatment - Child

I give my consent for my child to receive psychological and/or neuropsychological services from staff members of North Texas Neuropsychology & Behavioral Medicine Services.

I understand that services are provided on a confidential basis and records are disclosed only when properly authorized.

I understand that payment for services is due at the time of service, and that my appointment will need to be rescheduled if I am unable to fulfill this obligation.

I understand that if I cancel my appointment with less than 24 hours notice, or if I do not arrive for a scheduled appointment, any future appointments will need advance payment before being scheduled.

If applicable, I give consent for the staff of North Texas Neuropsychology & Behavioral Medicine Services to contact my insurance company to obtain information regarding my child's insurance benefits for the requested services. I understand that this contact is provided as a courtesy to me, and that the decision to reimburse me for the services provided rests fully at the discretion of my insurance company. I understand that I am responsible for the full cost of services provided, and that my insurance company's agreement to reimburse me for the services provided is an issue between me and my insurance company.

Signature of Parent or Legal Guardian:_____Date:_____

If signed by a guardian, please state legal basis for guardian status: _____

Receipt of HIPAA Disclosure

I acknowledge that I have received a copy of the HIPAA Disclosure Form utilized by North Texas Neuropsychology & Behavioral Medicine Services.

Signature of Parent or Legal Guardian:_____ Date:_____