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Licensed Psychologist PSY 10114

Consent for Treatment of a Minor

I, _____ authorize Sheryl B. Hausman, Ph.D., to see my
son/daughter _____ (date of birth) _____ for

- Counseling/Psychotherapy _____
- Assessment for Psychological Services _____
- Psychological Testing _____
- Family Counseling _____
- Child Interview _____

(Please check relevant procedure)

I agree to be responsible for payment in full for any services provided to my minor child.

Parent/Guardian Date

Sheryl B. Hausman, Ph.D. Date