



CONSENT TO TREAT A MINOR

I, _____, parent/legal guardian of the minor child, _____,
agree to have the child undergo a neuropsychological assessment and/or individual psychotherapy with

Judith D. Harrington, Ph.D.

Signed

Date

Witnessed

Date

IF JOINT CUSTODY, BOTH LEGAL GUARDIANS MUST SIGN.

Signed

Date

Witnessed

Date