CONSENT FOR TREATMENT

Peter A. Gold, Psy.D., P.A. Licensed Psychologist (FLPY7322)

Child, Adolescent & Adult Psychology

To my client, I am a practicing Mental Health Professional, Licensed Psychologist. I am completely independent in providing you with clinical services and I alone am responsible for those services. My professional records are separately maintained and no one else can have access to them without your specific, written permission.

The undersigned patient or authorized responsible party (parent, legal guardian or conservator) consents to and authorizes services to be performed by Dr. Peter Gold. These services may include psychological assessment, diagnostic procedures and other appropriate clinical therapies and/or clinical interventions.

The undersigned party understands they have the right to:

1) Be informed of and participate in the selection of the treatment modalities.
2) Request a copy of this consent.
3) Withdraw this consent at any time.

I have read, understand and agree with all of the above.

Thank you for the opportunity to provide you with Mental Health services.

Signature of Patient and/or Legal Guardian:

Date: