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CLINICAL PSYCHOLOGIST, 0810005677

CONSENT FOR THE TREATMENT OF A MINOR

I, ____ , am the parent or guardian of

___________________________________, a minor who is ________ years of age (the Minor).

I accept full financial responsibility for the services provided to the said Minor and will pay Dr. Walder for such services when billed at the customary and usual rates.

Signature____Date_______________

Address:____

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