

**Daniela Walder, PSY.D.**  
**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: \_\_\_\_\_  
\_\_\_\_\_



