THE FAMILY PSYCHOLOGICAL CENTER, P.A.
623 NORTH WALNUT STREET · HARRISON, AR 72601
PHONE: (870) 743-6225 · FAX: (870) 743-6006 · WWW.FPCHARRISON.COM

W. CHARLES NICHOLS, PSY.D.
CLINICAL PSYCHOLOGIST

Parental Consent for Mental Health Treatment of a Minor

Child's Name: _____

Date of Birth: _____

As the parent or legal guardian of the minor child named above, by signing below, I attest that I have the legal authority to make medical decisions for the minor and give my consent for my child to seek mental health services from Dr. Charles Nichols of Family Psychological Center, PA, for a period of one year following the date of my signature. Services may include psychological assessment and/or mental health counseling.

Any questions related to this form or the proposed mental health services can be directed to Family Psychological Center, PA, at 870-743-6225.

Please include a photocopy of your driver's license or state ID card with this signed form, which allows confirmation of your signature.

_____
Printed Name of Parent or Guardian

_____ _____
Parent or Guardian Signature Date

Reminder: A photocopy of the driver's license or valid state photo ID of the parent or guardian signing this form must accompany this form to be considered valid and complete.