The LifeWorks Group Inc
Making Life Work for You
1850 Lee Rd. Suite 250, Winter Park, FL 32789
Phone: 407-647-7005 Fax: 407-647-8874
www.lifeworksgroup.org
Email: info@lifeworksgroup.org

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

PATIENT: _________________________________ Birth date: ________________
(last name) (first) (middle)

I certify that I am the (circle one) father/mother/legal guardian of the above named child/adolescent and that I do have legal custody of the above named child/adolescent. I hereby give my authorization and consent for the above named child/adolescent to receive out patient assessment/therapy from ___________________________________.

Date: ________________________ Signature: ______________________

DIVORCE/LEGAL SEPARATION COLLECTION POLICY

It is my policy that the parent/guardian bringing a child/adolescent to our office for treatment, is responsible for payment of services rendered, at that time. If you have a financial arrangement for payment of the child's medical care, either oral or written, with the child's/adolescent's other parent or responsible party, you will be expected to pay for the child's/adolescent's care at the time of service and arrange for your personal reimbursement with the other party. In the event of a true emergency, treatment will not be denied to your child/adolescent.

I have read, understood and agree to the above policy:

____
(Print patient's name)

____ ____________
(Parent/Guardian Signature) (Date)