COGNITIVE THERAPY & CONSULTATION, LLC

597 Springfield Ave.
Summit, NJ 07901
(908) 273-3133

CONSENT FORM FOR TREATMENT OF A MINOR

I / We _____ _____ _____,

the parent(s)/guardian(s) of_____, hereby

give permission to: Dr. , of

Cognitive Therapy & Consultation, LLC to evaluate and treat my/our child/family.

I/ We understand that I/we reserve the right to revoke this consent at any time.

Parent or Guardian Parent or Guardian

Witness Date