



Indianapolis Christian Psychological Services

6337 Hollister Drive, Suite 101

Indianapolis, IN 46224

Voice: (317) 291-9007 Fax: (317) 291-09061

Consent for Treatment of a Minor

Child's Name: _____

Birth Date: _____

Address: _____

City / State: _____

Zip: _____

Phone: (____) _____

Parent or Guardian's Name: _____

Address (if different from child's): _____

City / State: _____

Zip: _____

Phone: (____) _____

I confirm that I am the legal, custodial parent or guardian of the minor child named above. I give my permission for the psychological assessment and / or treatment by Dr. Dobbs and Indianapolis Christian Psychological Services of this child. I understand that this permission will remain in effect during the duration of my child's services at Indianapolis Christian Psychological Services or until revoked by me in writing.

Signed: _____ Date: _____

Witnessed: _____ Date: _____