**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Child/Minor)**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent/Guardian Name)

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent/Guardian Name)

hereby authorize Comprehensive Psychological Assessment Services, PLLC (CPAS) and any of its providers to provide Assessment Services for my child/minor. I understand that CPAS’s primary responsibility is the child/minor’s best interest, and that their provider may involve me in the evaluation. The final report will be shared with both parents/guardians.

I understand that if payment is not received promptly for services rendered by CPAS to the child/minor, the services may be suspended and/or billed to all responsible parties.

CPAS will not engage in court proceedings or questions of custody.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

|  |  |  |
| --- | --- | --- |
| Patient Name: |  |  |
| Signature of Patient: |  | Date: |
| Parent/Guardian Name: |  |  |
| Parent /Guardian Signature: |  | Date: |
| Parent/Guardian Name: |  |  |
| Parent /Guardian Signature: |  | Date: |