EXETER PSYCHOLOGICAL ASSOCIATES, INC.

Cornerstone Commons
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Permission to Treat

PHYSICAL CUSTODY OF CHILD:
JOINT ____________ MOTHER _________ FATHER __________

LEGAL CUSTODY OF CHILD:
JOINT ____________ MOTHER _________ FATHER __________

SPECIAL CIRCUMSTANCES: YES ________ NO ________

Please explain: ____

I ____ being legal guardian, give permission
(please print)

for ____ ____________________
Child's Legal Name (please print) DOB

to be treated by Exeter Psychological Associates, Inc. I understand that I am responsible for all/any balances that are not directly paid to Exeter Psychological Associates, Inc. by my child's insurance carrier.

____ ____________________
Signature of Parent, or Legal Guardian Date

This authorization is valid unless it is rescinded by written notice to Exeter Psychological Associates, Inc. from the parent or guardian.

5/27/14