Nicole C. Pernod, Psy.D.
153 Roebling Street
4th Floor, Suite 12
Brooklyn, NY 11211
(347) 470-7377

Consent to Treatment

I do hereby seek and consent for my minor child to take part in treatment with Dr. Nicole C. Pernod. I understand that developing a treatment plan with Dr. Pernod and participating in regular collateral sessions to review our work toward treatment goals are in my child's best interest. I agree to play an active role in this process.

I understand that no promises have been made as to the results of treatment or of any procedures provided by Dr. Pernod.

I am aware that I may stop my child's treatment with Dr. Pernod at any time. My only responsibility is paying for the services I have already received. I understand that if payment for the services I receive here is not made, Dr. Pernod may stop my child's treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client

I, Dr. Nicole C. Pernod, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Nicole C. Pernod, Psy.D. Date