
Integrative Therapy of Greater Washington
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Rockville, Maryland 20852
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**CONSENT FOR CHILD OUTPATIENT TREATMENT**

We, the undersigned, are the legal guardians/custodians of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(date of birth **\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**, a minor child. We agree to his/her outpatient psychological services with Dr. Kari H. Moskowitz. No other mental health professional has the authority to make mental health decisions for this child.

We understand that premature termination of treatment can be harmful to a child. Because we jointly agree to initiate, authorize and participate in our child’s treatment, by our signatures hereon, we also agree that the decision to terminate our child’s treatment with be done jointly. In addition, we agree that we will jointly meet with Dr. Moskowitz prior to ending our child’s psychological treatment with her in order to develop a termination plan. We understand that the termination plan will involve, at least in part, one final session with our child and Dr. Moskowitz in order for him/her to have the opportunity to summarize the treatment and to say good-bye.

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Signature of Parent, Guardian/Authorized Representative Print Name

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Relationship to Patient Today’s Date

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Signature of Parent, Guardian/Authorized Representative Print Name

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Relationship to Patient Today’s Date

**IF BOTH PARENTS ARE LEGAL GUARDIANS, BOTH PARENTS MUST SIGN IN**

**ORDER FOR YOUR CHILD TO RECEIVE TREATMENT.**