



Aventura • Weston • Coral Gables  
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## Consent for Treatment

**Name of Patient:** \_\_\_\_\_

I voluntarily agree to give consent for treatment by Pediatric Psychology Associates for myself and/or my family members.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**If applicable, relation to Child/Patient:** \_\_\_\_\_

