THE INSTITUTE FOR CHANGE
(973) 734-0780

Morristown Office
44 Elm Street
2nd Floor
Morristown, NJ 07960

Montclair Office
460 Bloomfield Avenue
Suite 211
Montclair, NJ 07042

Mailing Address: IFC, PO Box 289, Caldwell, NJ 07006

CHILD/ADOLESCENT TREATMENT CONSENT

I, _____, give consent and authorization
(Print Name of Parent or Guardian)
for _____ to receive clinical services from the staff of
(Print Name of Patient)
The Institute For Change, including diagnostic and psychotherapeutic procedures.

Name of IFC Therapist: _____

I understand that I am responsible for the time set aside for service for me or my family members and that a charge will be made for such scheduled appointments if they or I do not keep them, unless 24-hours notice is provided. Insurance companies cannot be billed in such circumstances.

I have read this form and any questions I had have been fully addressed. I understand its contents and agree to its terms.

_____
Patient's Signature if 14 years or older (optional)

_____ _____
Signature of Parent or Legal Guardian (required) Date