Jan Ford Mustin, Ph.D.

Psychologist

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A Professional Corporation

PSYCHOLOGICAL SERVICES FOR A MINOR

Name of the child: ____

Date of Birth: _____________________________ Age: __________________ Sex: _____________

Name of father: ____

Name of mother: ____

Name of managing conservator: ____

Name of legal guardian: ____

Name of the person giving consent for psychological services: ________________________________

____

Description of the nature of psychological services to begin: _________________________________

____

____

Date treatment is to begin: ____

* * * * * * * * * * * * * *

I, ____________________________________, do hereby give consent for ________________________

to receive psychological services provided by Dr. Jan Ford Mustin, Ph. D., P.C. and Associates.

____________________________________ ____________________________________

Signature of person giving consent/ Date Signature of Witness/ Date