Ψ TREASURE VALLEY PSYCHOLOGICAL SERVICES

6003 OVERLAND ROAD, SUITE 301; BOISE, IDAHO 83709-3077

Ronald B. Tye, PsyD
Licensed Psychologist
Clinical Director

CONSENT FOR TREATMENT OF MINORS

PATIENT NAME: _____

DATE OF BIRTH: _____

PROVIDER (Check One): ☐Ronald B. Tye, PsyD

This is to certify that I give my permission to the provider listed above for treatment of my child.

This treatment may include individual or group psychotherapy, counseling and testing. It may include consultations with other associates including: Educational Psychologists, Career Counselors or Nutritionists.

Idaho State law mandates the reporting of certain types of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, and emotional or psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency. This treatment may also include referral to other appropriate State and County agencies for further counseling.

I am aware that per Idaho Statute Title 16-2428, if my child is over the age of 14, he/she must sign consent for this provider and his/her staff to provide information to me about the treatment being received. http://legislature.idaho.gov/idstat/Title16/T16CH24SECT16-2428.htm

My relationship to the patient:
☐Mother ☐Father ☐Step-mother ☐Step-father ☐Other:_____
Specify

My custodial rights are as indicated here, and I will provide legal documentation as proof:
☐Full legal custody ☐Joint custody; name of other custodial parent: _____.

_____
Signature of Parent/Guardian

_____
Printed Name of Parent/Guardian

_____
Street Address

_____
City, ST Zip

_____
Date