Ψ Cheryl Marsiglia, Ph.D.
Licensed Psychologist

Parent Agreement and Permission to Release Information

Patient Name: _____ Date of Birth: _____
Responsible Party: _____ Relationship: _____

Missed Appointments and Late Cancellation Fee Information

I acknowledge that a fee will be incurred for Late Cancellations (less than 24 hours notice) or Missed appointments and I understand I will be personally responsible for PAYMENT IN FULL of the charges of those events at the rates of:

- Missed Appointments $75
- Late Cancellations $50

Release of Information to Insurance Company

I hereby authorize Dr. Marsiglia to release information acquired in the course of my child's evaluation and/or treatment that is necessary for the purpose of filing insurance.

Insurance Company: _____

Parent (or Guardian) Signature_____ Date: _____

Consultation with Health Care Providers

I hereby request and authorize Dr. Cheryl Marsiglia to provide a copy of all evaluation reports to my child's health care provider(s):

Name of provider	Phone/Fax
_____	_____
_____	_____
_____	_____

I further give permission for my child's care provider(s) and Dr. Cheryl Marsiglia to discuss with each other any and all medical and psychological evaluations, treatments, and test findings, diagnoses, prognoses, prescribed medications, and clinical impressions.

Parent (or Guardian) Signature _____ Date:_____

My permission to mutually share treatment and test results as described above is also given for:

Name	Relationship to Patient
_____	_____
_____	_____

_____ I have received a copy of the privacy policy for my child's records.