Ψ TREASURE VALLEY PSYCHOLOGICAL SERVICES

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

Ronald B. Tye, PsyD
Licensed Clinical Psychologist
Clinical Director

M. Snider, PhD
Licensed Clinical Psychologist/
Neuropsychologist

Rachel Root, PhD
Licensed Professional Counselor

Michael Tandy, PhD
Licensed Clinical Psychologist

CONSENT FOR TREATMENT OF MINORS

PATIENT NAME:_____

DATE OF BIRTH:_____

PROVIDER:_____

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.

This treatment 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, emotional and 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.

_____
Signature of Parent/Guardian

_____
Printed Name of Parent/Guardian

_____
Street Address

_____
City, ST Zip

_____
Date