



The Nicholls Group
9965 North 95th Street, Ste. 101
Scottsdale, AZ 85258

Adolescent Social Skills Group

Informed Consent

Date: _____

Client Name: _____

Client Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Sex: M F

Notify in case of emergency _____

FINANCIALLY RESPONSIBLE PERSON

Name: _____ Relationship: _____

Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Date of Birth: _____

Employer: _____ Work Phone: _____

Financial agreement: I understand that the payment of \$325.00 is due in full on the first day the group is held. There are no refunds or credits for missed sessions.

Confidentiality: I understand that Dr. Ristich and Dr. Logerquist are mandated to report any suspected or known instances of child abuse. I understand that if I or my child discloses any past or current allegations of harm to the child, Dr. Ristich and Dr. Logerquist are obligated to make a report to the appropriate protective agency.

Consent for Participation: I acknowledge that I have been provided with a copy of the form "Psychologist-Patient services Agreement," and accept responsibility for reading this document and asking any questions that I may have regarding services provided to my child. I hereby certify that I have legal authority to seek requested services and give consent to Dr. Ristich and Dr. Logerquist to provide psychological services to my child. **Please note that in the case of unmarried or divorced parents, both parents' signed consent is required for the child's**

participation. I have had an opportunity to ask questions about any concerns I have regarding the above.

Signature of client or legal guardian

Date

Relationship if not client

Signature of client or legal guardian

Date

Relationship if not client