

WINSi
WESTERN INSTITUTE FOR NEURODEVELOPMENTAL STUDIES
AND INTERVENTIONS
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Informed Consent for Evaluation and/or Treatment

Patient Name: _____ DOB: _____

I hereby consent to evaluation and/or treatment of **myself / my child** administered at the Western Institute of Neurodevelopmental Studies and Interventions (WINSi). I agree that should I present my child for evaluation and/or treatment, that I have legal authority to do so. I understand that it is my responsibility to maintain scheduled appointments, provide payment for services rendered, and provide an accurate and complete account of current and past evaluation, treatment, symptoms and complaints.

Signature of Parent/Guardian

Date

Mr./Mrs./Ms./Dr.

Please print name

Relationship to Patient

Witness Signature /Pint/Date