

Mary Ann Evans, Ph.D.
Evans Cognitive Development Center
Clinical Psychologist, Psy 11935
Neuropsychological, Psychoeducational and Psychotherapy Services

28 W. Arrellaga St.
Santa Barbara, Ca. 93101
805 689-0849 maebe@verizon.net

1415 Ribe Rd.
Solvang, Ca. 93463

PERSONAL INFORMATION AND INFORMED CONSENT
Dependent (Child) Form

Child's Name _____ Birth Date _____ Age _____
School _____ Grade _____
Parent/Guardian's Name _____
Address _____ City _____ State _____ Zip _____
Telephone (Residence) _____ (Work) _____ E-Mail _____

Reason for Referral _____
Previous Psychotherapy, Counseling, Special Education or Psychiatric
Hospitalization: _____

Referred by _____

Person Responsible for Payment: _____

I apply for and consent to psychological treatment for my child with Dr. Mary Ann Evans and have chosen to use her assessment and/or psychotherapeutic services. I agree to assist in either the assessment or counseling process and support whatever changes that may take place. I understand that Dr. Evans is available to listen to me and to my child, and any psychotherapeutic techniques used will be with my informed consent. I will be responsible for the charges incurred. I understand that if my insurance does not reimburse me in full that I am responsible for the remaining portion. I also understand that full confidentiality of our contact will be respected unless the law requires disclosure or unless my account, due to non-payment, requires financial information be given to a collection agency or lawyer. I also understand that I must give 24 hours prior notice for any cancelled appointment, or I will be charged for that appointment.

Signed _____ Date _____