Pediatric Behavioral Health Institute
***2290** NW 2nd Ave Suite 3 Boca Raton, Florida 33432*
Office: 561-706-1004 Fax: 561-892-0268 Website: www.nikkiwoller.com

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INFORMED CONSENT FOR ASSESSMENT, TREATMENT AND DISCHARGE
Department of Children and Families Amendment

Client Name: ____________________________ D.O.B. __________________________

If I am a client of the Department of Children and Families, or if the Department of Children and Families or their designee is monitoring my family I understand that there are limits to my confidentially. I understand that there will be clinical reports sent to my case manager when ever I have an appointment. Those clinical reports will outline my progress as it relates to my treatment goals and the goals that were set forth on my dependency case plan.

By signing this form, I ____________________________, voluntarily grant permission for the SEAL Therapeutic Corporation and/or the Pediatric Behavioral Health Institute to conduct an assessment and subsequent treatment. I acknowledge that my rights have been explained; the limits of confidentiality and the grievance policy have also been explained.

____	______________________
Signature of Client	Date
____	______________________
Signature of Parent/Guardian	Date
____	______________________
Witness Signature	Date