

**Prairie Psychological Services, Inc.  
625 E 39<sup>th</sup> St., South Sioux City, NE 68776**

**PARENTAL/GUARDIAN CONSENT**

**Date:** \_\_\_\_\_

**Client:** \_\_\_\_\_

**Client's Date of Birth:** \_\_\_\_\_

I, \_\_\_\_\_, \_\_\_\_\_  
(Relationship to client)

hereby consent to have the above named child seen by clinical staff of Prairie Psychological Services, Inc. (PPS) for psychological/psychotherapy services. I also consent to having the information necessary to obtain reimbursement (including but not limited to monthly reports, evaluations, pretreatment assessments) be released by PPS to the appropriate third party payer(s) (e.g., private insurance company, Medicaid, the NE Medicaid managed care company, Medicare, or the Nebraska Department of Health & Human Services) that provides coverage to this child.

**Signed:** \_\_\_\_\_

**Witnessed by:** \_\_\_\_\_