

ILDIKO TABORI, PHD

INFORMED ASSENT

I, _____, A MINOR, GIVE MY INFORMED
ASSENT FOR PSYCHOTHERAPEUTIC TREATMENT AND/OR
PSYCHOLOGICAL/NEUROPSYCHOLOGICAL ASSESSMENT TO ILDIKO TABORI,
PH.D., A LICENSED PSYCHOLOGIST IN THE STATE OF CALIFORNIA.

I UNDERSTAND THAT I AGREE TO FULLY PARTICIPATE IN TREATMENT
AND/OR ASSESSMENT. I ALSO UNDERSTAND THAT I MAY TERMINATE
TREATMENT AND/OR ASSESSMENT AT ANY TIME.

SIGNATURE: _____ DATE: _____

NAME (PLEASE PRINT): _____