NOWLIN PSYCHIATRIC CLINIC, P.C.

SHARED CUSTODY ACKNOWLEDGEMENT TO TREAT FORM

(Shared Medical Decision Making)

If you have a joint custody arrangement for your child, please have the parent that will NOT attend your child's therapy sessions sign and date below. This for must be notarized.

I, ____the custodial Mother/Father (circle one) of

Of _________________________________ DOB___________acknowledge that my child will be seen

At The Nowlin Psychiatric Clinic, P.C. by Mary Nowlin, DO, DFAPA Child/Adolescent Psychiatrist for a

Psychiatric evaluation, medical treatment and/or counseling.

____ ________________________________

Signature Date

____

Printed name

Subscribed and sworn to before me this __________day of ____________________________________

____

Notary Public, Arizona

8414 East Shea Blvd.

Suite 102

Scottsdale AZ 85260

7075 W Bell Rd

Suite 12

Glendale AZ 85308