

# Neurodevelopmental Institute of New Hampshire

*Optimizing Potential Throughout the Lifespan*

*www.ninhllc.com*

## Permission for Services

Client Name:		Date of Birth:	
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I hereby authorize Neurodevelopmental Institute of New Hampshire, LLC, and any of its providers to provide mental health services to the individual named above. Mental health services may include individual therapy, family or group therapy, neurofeedback, psychological or neuropsychological testing, and referrals to other services.

Client Signature/Date: \_\_\_\_\_

Parent/Guardian 1 Name: \_\_\_\_\_

Parent/Guardian 1 Signature/Date: \_\_\_\_\_

Parent/Guardian 2 Name: \_\_\_\_\_

Parent/Guardian 2 Signature/Date: \_\_\_\_\_