



1489 Baltimore Pike, Suite 250  
Springfield, PA 19064  
T: 610-544-2110  
F: 610-604-9510  
www.springpsych.com

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

Child's name: \_\_\_\_\_  
(Print)

Date of Birth: \_\_\_\_\_

This is to verify that I do not know where to locate or how to contact the parent/guardian of the above child. I recognize that I am responsible to inform the parent/guardian of the above child that their child is in treatment with Springfield Psychological if I am able to contact them.

Parent/guardian Name: \_\_\_\_\_  
(Print)

Parent/guardian Name: \_\_\_\_\_  
Signature

Rev. 12/18/2017