

Karin Varblow, MD, PC

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SEPARATED/DIVORCED PARENTS AGREEMENT

I, _____ and I, _____

Parent

Parent

understand that Dr. Karin Varblow, MD, will be treating our

child/children, _____

Name(s) of child/children

For the purpose of medication management and psychoeducation.

We understand this evaluation/ treatment shall not be used for a current or subsequence legal custody dispute in court.

Parent 1 Name

Signature

Date

Parent 2 Name

Signature

Date