

IN CONSIDERATION OF  
PSYCHOTHERAPY CONDUCTED BY  
NON TESTIFYING THERAPIST

We, the undersigned, desire that Dr. Todd Larsen, Ph.D. (“the psychotherapist”)  
provide counseling services to our children/family\_\_\_\_\_

\_\_\_\_\_.

Further, we mutually agree, on behalf of ourselves and anyone acting on our behalf, including  
legal counsel, that we will not seek to have nor request that the psychotherapist be called as a  
witness to testify as to anything related to the counseling services s/he provides to our  
family/children.

Signed by: \_\_\_\_\_  
Date

Signed by: \_\_\_\_\_  
Date