CONSENT TO TREAT MINOR CLIENTS

Client's Name: ____

Date of Birth: ____

Parent or Guardian: ____

Home Address: ____

Preferred Number: ____

Work Address: ____

****If divorced or separated, please indicate custody status (physical and legal. I will also request a copy of a divorce decree before treatment begins.**

I, the undersigned, consent to the mental health treatment of the above-named minor and agree to cooperate and participate in his/her treatment as deemed necessary. My relationship to ____________________________ is as guardian/custodial parent.

________________________________ ________________________

Parent/Guardian Signature Date

________________________________ ________________________

Clinician Signature Date

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