

Bear Creek Family Behavioral Therapy Center
CONSENT FOR TREATMENT OF MINORS

Client's Name: _____

DOB: _____ Therapist Name: _____

This is to certify that I have given permission to the therapist named above for treatment of my child. This treatment may include individual, family or group psychotherapy. Psychological testing and assessment may also be a necessary part of treatment.

On occasion your therapist may consult with other professionals regarding your child. Consultation may be with teachers, educational psychologists, guidance counselors, physicians or psychiatrists.

California state law mandates the reporting of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse.

All actual or suspected acts of child abuse will need to be reported to the appropriate agency. In such an instance you may be referred to other State and County agencies for further counseling.

Sole Legal Custody

Joint Legal Custody

Other:

FOR OFFICE USE ONLY

Documentation of Sole Legal Custody Agreement obtained and copy of agreement on file.

Consent received from all responsible parties.

Signature of Parent /Guardian

Date

Printed Name of Parent /Guardian

Address

Signature of Parent /Guardian

Date

Printed Name of Parent /Guardian

Address