CONSENT FOR TREATMENT OF MINORS

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Licensed Marriage and Family Therapist
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Name of Minor _____
Date of Birth _____

This is to certify that I give permission for my child to be treated therapeutically by Nicole Bessire-Taylor, M.A., LMFT #46572. This treatment may include individual or group psychotherapy and counseling. This treatment may include consultations with other professionals for coordination of care.

California State Law mandates the reporting of certain types 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 be reported to the appropriate agency.

This treatment may also include referral to other appropriate State and County agencies for further counseling.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Printed Name of Parent/Guardian Witness/Title

_____
Street Address

_____ _____ _____
City State Zip Code

(____)_____
Phone Number