CONSENT FOR THE TREATMENT OF A MINOR

Child's name _____ Birth Date _____
Address _____
City _____ State _____ Zip _____
Home phone _____

Custodial Parent

Name _____Insured parent's DOB_____
Insured Parent's Employer _____
Work Address _____
City _____ State _____ Zip _____
Home phone_____ Work ph._____
Mom's cell ph._____ Dad's cell ph._____
Mom can receive texts on cell #: yes __ or no __. Dad can receive texts: yes __ or no __

Please circle one:

I give *permission/do not give permission* for the therapist to contact me via email.
If I give permission, my email address is: _____

_____ _____
Signature Date

In case of emergency, whom should we contact?

Name _____ Phone _____