Family Dynamics Counseling

Parent Consent for Treatment of a Minor

Minor's Name: _____

Minor's Birthday: _____

Mother's Name: _____

Father's Name: _____

Check one of the boxes below:

Please Circle the option that pertains to guardianship of the minor listed above as outlined in the most recent divorce degree and legal documents:

- Mother of the minor listed above has primary custody.
- Father of the minor listed above has primary custody.
- Mother and Father share custody of minor listed above.
- Other (Please explain): _____
  _____
  _____

By signing below, I consent to my child receiving psychotherapy services provided by:

Roxanna Oloumi-Johnson, PhD, LPC.

Guardian's Name (Please Print): _____

Relationship to Minor: _____

Guardian's Signature: _____

Date: _____

Family Dynamics Counseling Center
Roxanna Oloumi-Johnson, PhD
5900 Memorial Drive, Suite 216-C
Houston, TX 77007
info@familydynamicscc.com
713.459.9343
www.familydynamicscc.com