Jennifer Shtrum, LMFT# 46038
jenshtrummft@gmail.com

PARENT CONSENT FORM

I, the parent/guardian of _____, consent to my child's and my participation in the services with Jennifer Shtrum, MA, MFT #46038.

I understand the information regarding my family will be held in confidence with the exceptions of situations that may be harmful to the health and safety of others, including my children and myself.

I understand that it is our right to accept, refuse or stop services at any time. I understand all of the above and am interested in participation.

CONDITIONS OF ACCEPTANCE AND REQUEST FOR OUTPATIENT TREATMENT

1. **CONSENT FOR TREATMENT**: I (and/or the undersigned on behalf of the patient) voluntarily consent to allow Jennifer Shtrum, LMFT #46038 to provide such evaluation and/or care and treatment as an outpatient on a continuing basis as she may decide is advisable or necessary. I understand that I will be under care of a Marriage and Family Therapist.

If I am advised that such treatment should include a physical, neurological, or psychiatric examination, I agree that I shall request the same from my private doctor.

2. **SUPERVISION:** I understand it is my responsibility to provide adequate supervision for my child (ren) while he/she is in session with their therapist. I will stay in the waiting room during the entire time my child (ren) are in session.

3. **DISCHARGE**: All discharge planning should result form cooperative discussions between all parties concerned. Discharge dates and treatment plans are reviewed at least quarterly and involve input from the child, family, and therapist.

I certify that I have read the foregoing and have received a copy of it. As the patient, the patient's guardian or general agent, I agree to accept the above terms.

Parent Guardian Date: _____

Parent Guardian: Date: _____

Child (if over 12 years): Date: _____

Therapist: Date: _____

Client Name: