Christy Pulsford MSW, LISW-S, LICDC
GrowthInsight Counseling LLC
8050 Beckett Center Drive, Suite 314 | West Chester, OH 45069
Phone: (513) 847-3891 Fax: (513) 449-6214

CONSENT TO TREAT A MINOR

This is a consent to provide professional therapeutic services to children and adolescents.

I, _____, give my consent for Christy Pulsford, GrowthINsight Counseling LLC to provide assessment, psychotherapy, counseling and/or coaching services to my son/daughter, _____. I understand that my son/daughter may be asked to complete several forms which will help my therapist to better understand his/her symptoms and that individual or family therapy may be included in the treatment process. I also understand that the format of counseling may include any combination of the following: individual sessions with minor child, family sessions, and sessions with the parent/guardian.

_____ _____/_____/_____
Name of Patient/Client (please print) Date of Birth

_____ _____/_____/_____
Signature of Parent or Legal Guardian Date Signed