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GrowthInsight Counseling LLC  
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## 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 LLS, and associates or employees of Macks Psychology Group 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