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CONSENT TO TREAT A MINOR

This is a consent to perform professional therapeutic services for children and adolescents. I, _____, give my consent for Christy Pulsford or other associate of Macks Psychology Group to provide 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(s).

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

_____ _____/_____/_____
Signature of Patient/Client (if over age 13) Date Signed

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