



Hernandez Counseling & Assoc.

CONSENT TO TREAT A MINOR

Signature of both parents /guardians are required for the treatment of a minor. Exception to this requirement must be reviewed with your therapist prior to the first session (i.e.,custody court orders).

Childs Name _____ DOB _____

I (name of parent{s}) _____,parent(s)
of _____, authorize (name of therapist)

_____ to provide mental health counseling and
treatment to my child. By signing this consent to treat, I/we acknowledge that:

- **I/we have reviewed and agree to the Informed Consent For Treatment, Privacy Practices and Policies and Procedures for the private practice.**
- **I have reviewed and am fully aware of the California Law that mandates report for any and all forms of suspected child abuse and/or neglect.**

Signature Parent 1 : _____ Date : _____

Print Name : _____

Signature Parent 2 : _____ Date : _____

Print Name : _____

{ } Parent 2 is not required to sign , in lieu of signature the following document was
provided _____

{ } Other: _____