

Sara Taff Counseling, LLC
2015 Hamilton Street, Suite 206, Allentown, Pa 18104

PARENT/LEGAL GUARDIAN CONSENT FOR TREATMENT OF A MINOR

STUDENT/MINOR printed name:

Date of Birth: _____

Minor's Phone #: _____

As the parent or legal guardian with the authority to consent on behalf of the minor student named above, I hereby give my consent for the minor to seek counseling deemed advisable and/or necessary at Sara Taff Counseling, LLC. I agree and understand that while insurance may be billed for counseling/psychotherapy services, I am legally responsible for any and all charges incurred in providing this and/or other services by this office. This consent will be valid until the minor student reaches the age of 18, but may be revoked at any time by written notification.

Print Name of Parent/Guardian

Date

Signature of Parent/Guardian

Date

Parent/Guardian Contact Information: mailing address, phone number(s), email:
