JOHN C. HOUTON, PhD LPC CAADC

"Help & Hope for Children and Families"
32 S. 10th Street, Akron, PA. 17501
Phone: 717-341-6004 • Fax: 717-859-5674

PERMISSION TO TREAT MINOR

As the parent/legal guardian of _____, _____
Child's Name **DOB**

I have been advised that therapy provided by John Houton, PhD., can include physically interactive treatment with my child. I understand that therapy may result in highly emotional responses in myself/child.

I understand that my participation in my child's therapeutic process is essential for a positive outcome and I agree to fully participate in my child's treatment. I understand that I may raise questions or voice concerns at any time to the therapist(s). If I come to disagree with a treatment protocol, I understand that I have the right to stop or end treatment.

I have been made aware that treatment alternatives exist. I have advised the staff of any health issues to be considered in the treatment planning for my child.

With full understanding of the above, I give full and complete consent for John Houton to treat my child.

Parent/Legal Guardian Date

Parent/Legal Guardian Date

Child over 12 years of age Date

Therapist Date