CONSENT TO TREAT MINOR

We, (Parents Names)_____and_____,
are legal custodial parents with decision-making responsibility for (Minor's Name)
_____, a minor. (If sole legal custodian please attach a copy of the
Permanent Court Order Provision.) We authorize Tracey Ayers, LPC CACIII in her capacity as Licensed
Professional Counselor to begin the mental health assessment and treatment of said minor on (Date)
_____. Authorization will be in effect until such time as this psychotherapeutic relationship
is terminated.

As legal custodial parent, we understand that we have the right to information concerning our minor child
in therapy, except where otherwise stated by law. We also understand that this therapist believes in
providing a minor child with a private environment in which to disclose himself/herself to facilitate
therapy. We therefore give permission to this therapist to use her discretion, in accordance with
professional ethics and state and federal laws and rules, in deciding what information revealed by my
child is to be shared with us. This is my written consent to the mental health assessment and treatment of
minor child under the terms stated above.

IF APPROPRIATE, PARENT WITH DECISION-MAKING RESPONSIBILITY FILL OUT AND
SIGN THE FOLLOWING:

I also authorize _____ to sign any and all papers necessary for
client's treatment and to participate in treatment.

I also authorize _____ to transport client to and from scheduled
appointments.

Both parents must consent for treatment unless the treatment is court ordered or one parent is sole legal
custodian (please attach provision).

_____   _____
Signature of Parent/Guardian   Date

_____   _____
Signature of Parent/Guardian   Date

_____   _____
Signature of Witness/Provider   Date

———— Main Office ————

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———— Affiliate Addresses ————

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