CONSENT TO COUNSEL MINORS

Name of Parent/Guardian: _____Phone:_____

Name of Minor: _____ DOB: _____

Name of Therapist: _____

This is to certify that I give the above named therapist consent for treatment of my child. This counseling may include play therapy, family therapy, or referrals for psychological or educational testing. This counseling may also include referrals to other appropriate state, county or professional agencies for further consultation, if necessary.

Signature of Parent/Guardian: _____ Date:_____

Therapist Signature:_____ Date:_____

Jana Briggs Counseling, LLC
Sharon DeGuevara Counseling, LLC
Ashley Williamson Counseling, LLC
Hannah Kautz Counseling, LLC

8 W. Dry Creek Circle, Littleton, Colorado 80120