BEACH PSYCHOTHERAPY

1767 Grand Ave. #4 * San Diego, CA 92109
1-877-293-8123

Consent for Treatment for a Minor

In addition to signing a treatment agreement form for Beach Psychotherapy I am signing this form and I am aware that my child will be evaluated and/or treated by _____ a licensed professional.

I understand that consistency is extremely important to the effectiveness of counseling and that if my child does not attend his/her weekly sessions on a regular basis, _____will determine if treatment should continue.

I understand that it is important for my child to have his/her privacy and so the contents of the session will remain confidential between the child and therapist. General updates and progress can be communicated to you. Your treating therapist will explain how information will be shared with you. Please feel free to ask questions regarding this.

Name of Client:_____

Signature of Client:_____

Name of Parent/Guardian:_____

Signature of Parent/Guardian:_____

Witness:_____Date:_____