MICHELLE C. BRANCH, M.A., LMFT
MFC 50213
Alliance Therapy & Wellness
935 Riverside Avenue, Suite 12
Paso Robles, CA 93446
805-423-7207

Consent for Treatment of Minors

Patient Name____

Date of Birth____

Therapist____

This is to certify that I (we) give the therapist listed above permission to treat my (our) child. This treatment may include individual, family or group psychotherapy.

After initial evaluation with the child and family, a treatment plan and recommended procedures will be discussed in a meeting with the parent (s) and child or in a meeting with the child and his/her guardian (s).

Signature of Parent/Guardian______________________________Relationship to Child_____________

Signature of Parent/Guardian______________________________Relationship to Child_____________

Street Address____

City, Zip____