CONSENT FOR TREATMENT OF MINORS

Name: _____

Date of Birth : _____

Therapist : _____

- This is to certify that I give permission to CAV Family Therapy, Inc. and the Counselor listed above for the treatment of my child.
- This treatment may include individual or group psychotherapy, counseling and testing.
- This treatment may include consult Associates including Psychologists, MFT Interns, Career Counselors or Nutritionists.
- This treatment may also include referral to other appropriate State and County agencies for further counseling
- California State law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional psychological abuse.
- All actual or suspected acts of child abuse will need to be reported to the appropriate agency.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Printed Name of Parent/Guardian Date

_____

Street Address City State Zip Code

_____

Phone Number