CONSENT FOR TREATMENT OF MINORS

Name of child/adolescent: ____

This is to certify that I am the legal guardian for the above named child, and that I give permission to marie carter and associates to provide counseling for this child.

Types of counseling/therapy may include individual, family, play therapy, group counseling and testing. This treatment may also include referrals to other appropriate professional agencies.

I understand that I will be kept informed about treatment options, reserving the right to accept or decline treatment recommendations.

______________________________________ ____________________

Signature of Legal Guardian Date

______________________________________ ____________________

Signature of Counselor/Therapist Date