Doran Oatman, LCSW

A New Beginning Counseling
4131 Spicewood Springs Road
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512-843-0436

CONSENT TO TREAT MINOR CLIENTS

Client's Name: _____

Date of Birth: _____

Parent or Guardian: _____

Home Address: _____

Telephone Number: _____

Work Address: _____

If divorced or separated, please indicate custody status (physical and legal) I will also request a copy of a divorce decree before treatment begins.

_____

I, the undersigned, consent to the mental health treatment of the above-named minor and agree to cooperate and participate in his/her treatment as deemed necessary. My relationship to _____ is guardian/custodial parent.

_____ _____
Parent/guardian Signature Date

_____ _____
Clinician Date