Counseling
by Penny Haight, M.Ed., LPC-S

# Minor Consent

Name of Person Giving Consent: _____

Your Relationship to Minor (check one):

☐ Parent ☐ Step Parent ☐ Foster Parent ☐ Legal Guardian ☐ Other _____

Is there shared custody of this minor? Yes or No

Are the custody arrangements documented by the court? Yes or No

If yes, Counseling By Penny must obtain a copy of this document before the appt. _____

Name of Minor: _____ Date of Birth: _____

This is to certify that I give permission to Counseling by Penny Haight M.Ed., LPC-S, PLLC for treatment of my minor child.

This counseling may include individual or family psychotherapy, education, and assessment.

*I consent to the following psychotherapy services for the minor named above (check & initial all that apply):*

☐ _____ Individual/Family Therapy

☐ _____ Biofeedback

As a parent/legal guardian, I understand that I have the right to information concerning my minor child in therapy except where otherwise stated by law. I also understand that Counseling By Penny Haight believes that providing a minor child a safe and private environment in which to disclose his or her feelings and emotions can facilitate therapy. Therefore, I give permission to Counseling By Penny Haight to use their discretion in accordance with professional ethics and state law in deciding what information revealed by my child is to be shared with me.

X _____ _____

*Parent/Guardian Signature* *Date*