Lisa Hayes, M.S., MFC # 48886
Licensed Marriage & Family Therapist
161 Fashion Lane, Suite 110, Tustin, CA 92780 (949) 829-3397

CONSENT TO TREAT A MINOR

Minor client(s): Name/DOB: ____

Minor client(s): Name/DOB: ____

Minor client(s): Name/DOB: ____

Minor client(s): Name/DOB: ____

Parent/legal guardian(s): ____

____

I/We, ____ give permission

to/authorize Lisa Hayes, M.S., MFC # 48886 to assess, diagnose, and treat my/our

child(ren)____

____

This authorization will expire one year from the date below.

I/We understand that confidentiality is an essential part of the relationship my child has with his/her therapist. I/We agree to respect that relationship and the limits of it. If I/We have questions or concerns about my child or his/her participation in therapy, I/We agree to contact the therapist myself and request a joint session with my child.

Should I/We decide to terminate treatment for my child for any reason, I/We agree to notify the therapist in advance and, if it is appropriate, allow my child an additional session(s) to discuss the progress that was made thus far, the significance of the relationship and its ending.

_____________________________________ _________________

Parent/legal guardian Date

_____________________________________ _________________

Parent/legal guardian Date