AUTHORIZATION TO TREAT A MINOR

The State of Pennsylvania, for the purposes of mental health counseling, defines a minor as any child under the age of fourteen.

LIFE STRATEGY CONSULTANTS, LLC
Professional Counseling, Consulting & Educational Services

Client Name [Minor]_____ Date of Birth ____/____/____

Address _____

City _____ State _____ Zip _____

Phone (_____)_____

When treating minors, Life Strategy Consultants, LLC makes every effort to obtain permission from both biological parents and/or guardians prior to beginning treatment. We believe that this united support is vital for effective treatment of minors. If permission cannot be obtained from both biological parents and/or guardians, treatment will proceed at the discretion of the clinician.

By signing below, parents/guardians understand and agree that they are privileged to confidential information regarding their child's treatment, but in order to engage in the most effective treatment they may or may not be present in the counseling room during treatment. Additionally, in the interest of developing a trust relationship between child and clinician, the parents/guardians give the clinician permission to reveal or withhold information that in their clinical judgment is necessary to best help and protect the child. The only exception to this discretion would be in the case of:

_____

_____

_____

Parent/Guardian Signature _____ Date _____

Relationship to client _____

Witness Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Relationship to client _____

Witness Signature _____ Date _____

Please provide a COPY of any court orders that provide clarification of custody issues, medical rights, guardianship, or any other judgements related to the care and custody of this minor.

Revised April 2018