Arrow Counseling Services, LLC

CONSENT FOR TREATMENT OF MINOR/CHILD ASSENT FORM

This is an authorization for _____ to provide treatment and/or diagnostic services
Therapist Name

to my child/adolescent _____.
Child Name

By signing this Consent for Treatment, I certify that I have legal custody or joint legal custody of my son or daughter and thus, can legally consent for treatment of my child. (Please provide documents such as court order or custody agreement)

_____ _____
Parent or Legal Guardian Date

_____ _____
Parent or Legal Guardian Date

CHILD ASSENT

I understand that my parent or guardian may consent for my treatment; however, I have also been asked to give my assent for my own treatment. By signing below, I realize that the therapist listed above has elicited my own assent for treatment.

_____ _____
Child's Name Date

_____ _____
Therapist Name Date