TheTherapyDr.

850 E. Higgins Rd Suite 119 Schaumburg IL 60173 Telephone:847-242-1511

Consent for Counseling Services

1. The minor(s) named below live in my home and I am 18 years of age or older. Yes No

2. Name of Child:(First and Last)_____ Child's Date of Birth:_____

3. Your Name (please print)_____

4. Your relationship to child: Parent Stepparent Guardian Grandparent Other

5. I hereby swear that I have the following **legal custody** (circle appropriate): Joint Sole None

6. I hereby swear that I have a legal right to obtain treatment for the above-named child(ren): Yes No

If the answer to above questions is "No," counseling services cannot be provided to the above-named child(ren) until a copy of the court order which names you the legal custodian is provided to this office.

- I have read, understand, and agree to the *Confidentiality Statement* and the *Informed Consent/Duty to warn* (exceptions to confidentiality) for Agnes Lepicka MA LCPC
- I am aware of its content and policies and understand that a copy of this *Signature Statement* will be a part of my case record.
- I have read it and if necessary, I have discussed and clarified my understanding of it with a representative Agnes Lepicka MA LCPC. I agree to abide by the terms/policies set forth in this document.
- I consent to have the above named minor(s) receive therapeutic services provided through Agnes Lepicka MA LCPC without a parent or guardian present.

_____ _____
Signature of person authorizing consent of services (Parent/ Guardian) Date

_____ _____
Signature of person authorizing consent of services (Parent/ Guardian) Date

_____ _____
Signature of child 12 years old or older Date

_____ _____
Witness Date