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CONSENT TO TREAT MINORS

I/We, the parents of _____ _____
(name) (date of birth)

give permission to Sharona Stone, MEd, LCSW, DCH, to provide treatment services to my/our child.

Signatures below indicate an understanding that children have the same rights to confidentiality as Adults. If an important issue arises that parents should be made aware of, all efforts will be made to encourage the sharing of this information by the child with the parents while receiving the therapist's support during a session.

Signature: _____ Date: _____

Signature: _____ Date: _____

Children of Divorced Parents

When parents are divorced clarification is needed, please respond accordingly to questions below (as documented in your Court orders).

___ I have sole - Medical Decision-making Authority.
___ We have joint - Medical Decision-making Authority

___ We have joint and I have informed the other parent of this appointment and provided him/her with your contact information.

Name of the other parent: _____

Contact telephone #: _____

Email address: _____