Dr. Sharon Phillips, LLC
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(Rev. 4/19)

CONSENT TO TREAT A MINOR

This is a consent to perform professional therapeutic services for children and adolescents.

I, _____, give my consent for Dr. Sharon Phillips
(Print parent name)

To provide therapy services to my son/daughter, _____.
(Print child's name)

I understand that my son/daughter may be asked to complete several forms which will help my therapist to better understand his/her symptoms and that individual or family therapy may be included in the treatment process.

I also understand that the format of counseling may include any combination of the following: individual sessions with minor child, family sessions, and sessions with the parent(s).

_____ _____
Signature of Parent/Guardian Print Child's Name

_____ _____
Child's Date of Birth Signature of Child (if age 13 or older)

_____
Date Signed