

Dr. Sharon M. Phillips & Associates, LLC
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(Rev. 2/12)

CONSENT TO TREAT A MINOR

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

I, _____, consent to Dr. Sharon M. Phillips & Associates, LLC
(Print parent name)

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

I understand 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