Maria Schmid & Partners
Psychologists and Mental Health Services

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CONSENT FOR TREATMENT

I or We, _____,_____ consent to

(name of therapist) _____ providing counselling/psychological services to:

_____ _____
(name of minor / dependent adult) (date of birth dd/mm/yyyy)

_____ _____
(name of minor / dependent adult) (date of birth dd/mm/yyyy)

_____ _____
(name of minor / dependent adult) (date of birth dd/mm/yyyy)

_____ _____
(name of minor / dependent adult) (date of birth dd/mm/yyyy)

Please circle the appropriate marital situation (a,b,c,d or e):

a) Biological parents residing together.
   (consent for treatment form can be signed by one biological parent)
b) Biological parents not residing together – sole custody agreement.
   (consent for treatment form can be signed by parent with sole custody)
c) Biological parents not residing together – joint custody agreement.
   (consent for treatment form must be signed by both biological parents)
d) Biological parents not residing together – no current custody or separation agreement in place.
   (consent for treatment form must be signed by both biological parents)
e) Other situation, please describe: _____

Contact Info:

Mother:_____ Father: _____
(name) (name)

_____ _____
(primary phone number) (primary phone number)

I confirm that the above is true and accurate:

_____ _____
(signature of mother) (signature of father)

_____ _____
(date dd/mm/yyyy) (date dd/mm/yyyy)

_____ _____
(signature of witness) (signature of witness)

_____ _____
(date dd/mm/yyyy) (date dd/mm/yyyy)