Susan Chakmakian, M.A., M.F.T.

Consent To Treat Minor

We (I) _____Date of Birth_____
(the parent(s)/legal guardian - *please print*)

and _____Date of Birth_____
(the parent(s)/legal guardian - *please print*)

are legal custodial parents with decision making responsibility for:

Name_____Date of Birth_____

Name_____Date of Birth_____

Name_____Date of Birth_____

(If sole legal custodian, please attach a copy of the court order.)

We give permission to Susan Chakmakian, LMFT (therapist), to provide psychotherapy for our child(ren) named above. This treatment may be conducted in an individual, conjoint or family therapy session as deemed most appropriate by the therapist.

We are responsible for payment of all treatment except where other arrangements have been made. In the case of treatment being denied for payment, I will take full responsibility to pay the amount due.

This is effective for one year after date of signing unless stipulated below:

Effective date: _____End date:_____

It is without pressure or coercion that I sign this consent. **Do not sign this form if any of the statements above are incorrect or you will be committing a crime punishable by a fine, imprisonment or both.**

Signature: _____Date:_____
(parent / legal guardian)

Signature: _____Date:_____
(parent / legal guardian)

Witness: _____Date:_____
Therapist

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