Erin M. Thomas, MA, LPC

Erin M Thomas Therapy, LLC. **1200 S. College Ave, Suite 208**
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CONSENT FOR PSYCHOTHERAPY TREATMENT FOR A MINOR

I, _____ give my permission to Erin M. Thomas, MA, LPC
(Parent/Guardian)

to meet with my child/children _____, _____,
(Minor's Name) (Minor's Name)

_____, _____, _____
(Minor's Name) (Minor's Name) (Minor's Name)

for the purpose of psychotherapeutic treatment.

I certify that I have the legal authority to give consent for treatment.

Please check one:

_____ I am married to the child's other parent/guardian.
_____ I am not married to the child's other parent/guardian and decision making responsibilities have not been established in court.
_____ I have sole decision making for my child and can present therapist with paperwork verifying my authority.
_____ I have joint decision making for my child, and thus understand the therapist will have to receive consent from the other parent before treatment can begin.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____