Carolina Counseling Professionals
— Where Hope and Healing Begins —

Consent for Mental Health Treatment (Minor)

I, _____, do hereby authorize that my child,
Parent/Legal Guardian's Name

_____, may receive mental health treatment provided by
Client's Name / Date of Birth

Carolina Counseling Professionals, LLC and all practicing therapists. Appointments including assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as considered necessary and advisable. provided under the establishment of Carolina Counseling Professionals, LLC and all practicing therapists. Care, treatment or services may be stopped at any time. By signing, you acknowledge that you have both read and understood all the terms and information contained herein. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear. I am aware that all custodial parents, and legal guardians must give consent before treatment begins. In the event of divorce or separation, documents declaring primary custody of signing parent must be presented to the therapist. If the child is in the custody of a legal guardian, proof of guardianship must be presented to the therapist. If there is a Guardian Ad Litem appointed to the child, we must have a Medical Release of Records signed to coordinate care.

_____
Printed Name of Parent/Legal Guardian

_____ _____
Signature of Parent/Legal Guardian Date

156 Milestone Way, Suite D
Greenville, SC 29615
203 Central Park Lane
Seneca, SC 29678
864-973-1359 – Office
864-973-8965 – Fax
carolinacounsel@gmail.com