CONSENT FOR TREATMENT OF A MINOR CHILD

The following statements provide your legal consent to and financial responsibility for counseling services to a minor child at **Balance Stress Management & Therapy** 620 Wing Street, Unit 3 Elgin, IL 60123. These statements are important to protect the child, the parent/guardian/conservator, and the therapist. Please carefully review this information and sign where indicated. You are requested to discuss any question you may have with the therapist.

STATEMENT OF RESPONSIBILITY AND GRANT OF PERMISSION FOR THERAPY

I am the: Natural Parent: [ ]

Legal Guardian: [ ]

Managing Conservator of [ ]

(Name of minor child)

____

I am legally responsible for the child named above and grant permission to

____

(therapist)

at **Balance Stress Management & Therapy** to conduct therapy with this child.

I accept responsibility for payment of all fees at the time of service due to **Balance Stress Management & Therapy** for services provided to this child as outlined in the Financial Policy.

Signature: ________________________________ Date: _________________

DUTY TO WARN NOTICE

Balance Stress Management & Therapy is committed to the confidentiality and privileged communication with all clients. There are, however, several exceptions. According to Illinois law, any evidence of child abuse must be reported to the authorities. If any individual intends to take harmful, dangerous, or criminal action against another individual, or against himself/herself, it may be the therapist's duty to report such action or intent.

Parent/Guardian Signature: ____

Date: _______________