REBECCA FROCK
COUNSELING

CONSENT TO TREAT A MINOR CHILD

CLIENT NAME: _____ DOB: _____

My signature on this form means that I agree to allow my minor child (under 14) to participate in counseling services provided by Rebecca Frock L.P.C.C., Ph.D. (c). I understand that this is a general consent for any mental health treatment or services that Rebecca Frock L.P.C.C., Ph.D. (c) provides for my child. I also understand that while my child is receiving counseling, I or another legal guardian must remain in the lobby for the entirety of the session.

_____ _____

SIGNATURE OF PARENT / GUARDIAN DATE

_____

PRINTED NAME OF PARENT / GUARDIAN

_____ _____

SIGNATURE OF PARENT / GUARDIAN DATE

_____

PRINTED NAME OF PARENT / GUARDIAN