journeys
COUNSELING MINISTRY

CONSENT FOR TREATMENT OF MINOR

Minor Information		
Name:	Date of Birth:	
Street:		
City:	**State:**	**Zip:**
Home Phone:		
Parent or Guardian Information		
Name:	Relationship to Minor:	
Street:		
City:	**State:**	**Zip:**
Home Phone:	**Work:**	
I Give Permission		
Therapist's Name:		

This is to certify that I give permission to the counselor listed above for treatment of my child. This treatment may include individual or group psychotherapy, counseling and testing.

Confidentiality

Your child will be told that what they share in their session will remain there. He/she will be told that he/she may choose to share with you any information he/she feels comfortable sharing. You are encouraged to help your child create a safe place for counseling by not probing for information. If you have questions regarding the issues (not content) your child is working on please give your child's counselor a call. Your child will be assisted to share pertinent information that relates to his/her safety with you. The exceptions to confidentiality are: danger to self or others, inability to care for self or if child abuse is suspected.

Child Abuse reporting

California State Law mandates the reporting of child abuse including physical abuse, sexual abuse, emotional abuse and neglect. All actual or suspected acts of child abuse must be reported to the Child Abuse Registry. If you or your child share information about abuse or actual abuse is seen, the above counselor will inform the appropriate agencies.

_____ _____

Parent or Guardian Signature Date

_____ _____

Therapist Signature Date

714.957.1973
866.809.0011

PO Box 10670
Costa Mesa, CA 92627

www.journeyscounseling.com