William Arndt, MA, MFT, LADC
Licensed Marriage and Family Therapist
Licensed Alcohol and Drug Counselor

Consent To Treat Minor

I, _____*(parent/guardian)* , give my consent for _____ *(child)*, to receive counseling/therapy from William Arndt, MA, MFT, LADC.

I agree to abide with the laws of confidentiality and to respect the therapist/client relationship the clinician may develop with my child. I have been advised of the potential risks, as well as benefits, typically associated with the counseling process. I give my full consent and cooperation to this approach and agree to hold William Arndt, MA, MFT, LADC harmless, except regarding reasonable and customary care. In some cases in which the custody of the minor child is at issue, the custodial parent may be asked to present a copy of the custodial order, which will become a part of this permanent file.

_____

Print Name of Minor Child Date

_____

Print Name of Parent/Guardian Date

_____

Signature of Parent/Guardian Date

_____

William Arndt, MA, MFT, LADC Date