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PARENT'S CONSENT TO TREATMENT FOR A MINOR

I _____ consent to psychological treatment for:

Minor Child(ren) _____

I understand that I have a right to knowledge of any diagnosis that might be made on my child and that I have a right to an explanation of treatment rationale.

I understand that the contents of counseling/psychotherapy sessions with a child must be kept confidential in order to allow the child to be successful in the process.

I understand that there is no implied or express guarantee of treatment outcome and that any concerns I might have about my child's progress can be raised with my child's therapist.

Parent's Signature

Date