LIGHT OF HOPE COUNSELING SERVICES, INC

Kiana Kalaghichian, LCSW

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CONSENT FOR THE MENTAL HEALTH TREATMENT OF A MINOR

I, ____, give my permission Name of Parent or guardian of child

for my child, ______________________________________, ____________________,
Full Name of Minor Birth Date of Minor

To be treated and/or evaluated by Kiana Kalaghichian, in psychotherapy. I also understand that in order for therapy to be successful with any individual, their confidentiality needs to be respected, even in the case of a minor child, with exceptions of if the minor is a danger to him/herself or to others.

The provider has explained to me the proposed treatment plan, the general nature and extent of the benefits and risks involved in the treatment, and alternative treatment options, if any. I understand that this permission to treat with respect for my child's confidentiality is given with my full consent. This consent will be valid throughout the duration of therapy, or until the following date _________________(date consent expires)

Consent granted for:
____Individual psychotherapy
____Family psychotherapy
____Group psychotherapy

____
Parent or guardian's signature Relationship to minor Today's Date

____
Name, Address and Phone # of Parent or guardian (Street, City, State and Zip)

____
Other parent or guardian's signature Relationship to minor Today's Date

____
Name and Address of other parent or guardian (Street, City, State and Zip)

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Address of minor (Street, City, State and Zip)