**Michelle Schmidt, NCC, LPC**

**33 South Main Street**

**Mullica Hill, NJ 08062**

**856-418-1950**

**Consent For Treatment of Minor(s) Children**

Child’s Name: Date of Birth:

Child’s Name: Date of Birth: \_\_\_\_\_\_

This section must be completed by both parents or legal guardian of each child who attends session.

**FOR SOLE LEGAL CUSTODY:**  I, , am the sole legal custodial parent of the above named child (or children) and give my permission to Michelle Schmidt, LPC to provide psychotherapy services to my child (or children). I fully understand the nature and purpose of these services, including possible benefits and risks, and have discussed any concerns with Michelle Schmidt. I understand that it will be expected that I provide a copy of any divorce agreement, if relevant, to give evidence of the custody arrangements. **It is understood that if this case is taken to court for any reason, I CANNOT render an** **opinion on custody.**

**FOR JOINT LEGAL COSTODY:** We, , are the joint legal custodial parents of the above named child (or children) and give our permission to Michelle Schmidt, LPC to provide psychotherapy services to our child (or children). I fully understand the nature and purpose of the services, including the possible benefits and risks, and have discussed any concerns with Michelle Schmidt. **It is understood that if this case is taken to court for any reason, I CANNOT render an opinion on custody.**

If your child is 14 years of age, all material discussed during the psychotherapy sessions is confidential and can be released only with their permission. My role as a therapist is to help minors learn to communicate openly and directly with their parents. I typically involve parents in the counseling process, at your child’s pace. Furthermore, I’m consenting that I will accept Michelle Schmidt, LPC judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's wellbeing.

Parent: Date:

Parent: Date:

Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Children age 14 and above sign this form)