Consent to Treat Minor

Please fill out “Consent to Treat Minor” forms for each minor participating in therapy

Child’s Name: _____ Sex ____ Age ____ DOB ___/___/___
SS#: _____

Child’s primary address: _____ Zip Code: _____

Please list any medications minor is on
_____

Primary Care Doctor _____ Date last seen _____
Psychiatrist _____ Date last seen _____

List any head injuries, past or present major illnesses or allergies
_____

School_____ Grade _____

Special Education Accommodations? _____ GPA _____

Insurance Information:
Client’s Relationship to Primary Insurance Holder: self child other _____

Insurance Company: _____ ID #: _____
Group/Plan #: _____Group Name: _____

Primary Insured Name (Please identify name of the primary insurance holder):
_____ Primary Insured SS#:_____

Primary Insured DOB: ___/___/___
Primary Insured Address:
_____

Father’s Name: _____ SS#: _____
DOB ___/___/___

Address: _____ Zip Code:_____
Phone _____(Permission to contact via phone Y/N)

Mother’s Name: _____ SS#: _____
DOB ___/___/___

Address:_____ Zip Code:_____
Phone _____ (Permission to contact via phone Y/N)

Guardian's Name: _____ SS#: _____
DOB ___/___/___

Address:_____ Zip Code:_____

Phone _____ (Permission to contact via phone Y/N)

In Case of Emergency Contact:

Name _____Relationship _____ Phone _____

Name _____Relationship _____ Phone _____

Please circle all that apply to minor and family:

Divorce Legal Separation Custody Guardianship Restraining Orders Current Litigation Issues Probation

Any issues concerning Divorce, Custody, Guardianship, Probation and/or Restraining Orders will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records.

I, (print name) _____, am the mother/father/legal guardian (circle one) of _____, and I authorize Cynthia Lee Shelton LCSW to provide psychotherapy to said minor. I also agree to be legally responsible for any charges said minor may incur during therapy with Cynthia Lee Shelton LCSW. _____ (initial here)

Signature: _____ Date:_____

(Must be signed for services to begin)

I, (print name) _____, am the mother/father/legal guardian (circle one) of _____, and I authorize Cynthia Lee Shelton, LCSW to provide psychotherapy to said minor. I also agree to be legally responsible for any charges said minor may incur during therapy with Cynthia Lee Shelton, LCSW. _____ (initial here)

Signature: _____ Date: ___/___/___

(Must be signed for services to begin)

Witness Signature: _____ Date: ___/___/___

Cynthia Lee Shelton, LCSW
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