

BodyWise Psychotherapy

Counseling that moves you.

Susana Potter, LMHC, R-DMT

Consent to Treat Minor

Name of Minor: _____

Age _____ Birth Date _____

I _____ am legal custodian for
(Print name)
the above named minor.

Please Check One:

I have legal authority to consent to treatment of the minor without obtaining consent or approval of another person

I have joint custody of the minor pursuant to a decree that requires both my consent and the consent of another person.

By signing I hereby authorize Susana Potter of BodyWise Psychotherapy to provide counseling to the minor in connection with substance abuse, mental health and/or other personal problems.

Parent or Legal Guardian

Date

Witness

Date