Deborah A. Lowe, PsyD, LMFT
ChristianChildTherapy.com
License #46251

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CONSENT TO MINOR'S TREATMENT

Child's Name: _____ Birthdate: _____

Address: _____ City: _____ CA ZIP _____

Home Phone: _____ Current School: _____

EMERGENCY INFORMATION

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Has the child had prior psychological treatment: ◯ YES ◯ NO

If yes, please indicate where and when: _____

_____

_ Is your child currently being treated by a physician: ◯ YES ◯ NO

If yes, for what condition and by whom: _____

_____

Is your child currently taking medication: ◯ YES ◯ NO

If yes, please specify what is being prescribed and why:

_____

_____

Christian Child Therapy

CANCELLATION POLICY
To avoid being charged for a missed session, appointment must be cancelled at least 12-hours ahead of scheduled date and time.

CONFIDENTIALITY
I understand that therapy and therapy records are confidential and that no information will be released to anyone without my signed consent. The law releases therapists from confidentiality in cases where a patient is a danger to self or others, in cases of child or elder abuse, and when the court subpoenas records.

CONSENT
I consent to psychotherapeutic treatment for my child with **Deborah A. Lowe, PsyD, LMFT** as discussed.

By entering your typed name, you agree that the provided "e-signature" will be the electronic representation of your signature for the purposes of this document. You further understand your electronic signature will have the same legally binding effect assigning your signature using pen and paper. Submission of this signed and dated document shall evidence acceptance of your acknowledgement and consent.

SIGNATURE **DATE**

_____ _____
Patient/Parent/Conservator/Guardian

SIGNATURE **DATE**

_____ _____
Patient/Parent/Conservator/Guardian