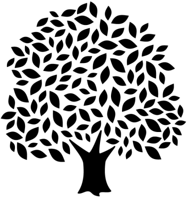

Beech Tree
Consulting &
Psychological Services

Consent to Treatment (Child and Adolescent)

I do hereby seek and consent to my child receiving mental health treatment provided by ________________________________, a mental health professional as defined by Indiana law. Treatment may include individual psychotherapy, group psychotherapy, psychological testing, and/or family therapy or a combination of services. I understand that developing a treatment plan with this mental health professional and determining the most appropriate combination of services is critical for my child's effective treatment.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this clinician.

I am aware that I may stop my child's treatment with this mental health professional at any time. If I choose to stop treatment for my child, I will still be responsible for paying for the services already received.

I understand that I am consenting to my child receiving only those mental health services that the above named mental health professional is qualified to provide within the scope of their professional license, certifications and/or training or within the scope of the license, certification and training of those mental health professionals directly supervising the care your child is receiving.

My signature below shows that I understand and agree with all of these statements.

____ ____________________
Signature of parent or legal guardian Date

____ ____________________
Printed name Relationship to client

____ ____________________
Signature of parent or legal guardian Date

____ ____________________
Printed name Relationship to client

____ ____________________
Signature of Mental Health Professional Date

________Copy accepted by parent/legal guardian ________ Copy kept by therapist

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