Miss Racheal's Counseling, LLC Licensed Marriage and Family Therapist Racheal Elrod-Edwards, LMFT
2498 W New Orleans Street Broken Arrow, OK 74011 Phone: (539) 777-1129 Fax: (888) 371-9410

Consent To Treat Minor

(Please Complete a Separate "Consent to Treat Minor" Form for each minor participating in therapy) CHILD'S NAME:_____ DOB: ___/___/___

Home Phone: _____SS#:_____-____-_____ Age:_____

PrimaryAddress:_____,_____,_____,_____

(City) (State) (Zip) PARENTS:

(Name all parents/step-parents/legal guardians. CUSTODIAL parent(s) must sign form)

Mother: _____Spouse:_____

Address (or "same"):_____,_____,_____,_____

(City) (State) (Zip)

SS#:_____-____-_____ DOB:___/___/___ Age:__ Cell Phone:_____

Occupation:_____ Work Phone:_____

Home Phone:_____

Father: _____Spouse:_____

Address (or "same"):_____,_____,_____,_____

(City) (State) (Zip)

SS#:_____-____-_____ DOB:___/___/___ Age:___Cell Phone:_____

Occupation:_____ Work Phone:_____

Home Phone:_____

Guardian: _____ Spouse:_____

SS#:_____-____-_____ DOB:___/___/___ Age:___Cell Phone:_____

Address (or "same"):_____,_____,_____,_____

(City) (State) (Zip)

Emergency Contact:

Name:_____ Relationship: _____Phone:_____

Name:_____ Relationship: _____Phone:_____

I, (Print Name)_____ attest that I am the custodial parent of above named minor, and I authorize child to participate in psychotherapy with this office. I agree and understand that while insurance may be billed for psychotherapy services, I am legally responsible for any and all charges incurred in providing this and/or other services by this office. Copies of documentation of legal custody of child, and any other legal issues pertaining to child must be provided on, or before date of first visit. Copies of these documents will be kept in child's record.

_____ _____

CUSTODIAL PARENT (Mother/Father/Guardian - Circle One) DATE