Journeys Counseling Group LLC.

Consent for counseling services to minors

In order for minor children/adolescents to receive psychological services, it is necessary for the parent or legal guardian to grant permission for such services to occur.

Names and date of birth of child(ren) to receive psychological services:

Name ____ Date of Birth __________

Name ____ Date of Birth __________

Name of person requesting services ____

Your relationship to child(ren): Parent Stepparent Guardian Grandparent Other

Are you legal parent or custodian to above-named children? Yes No

I____ hereby swear that I have legal right to obtain treatment for the above-named children: Yes No

In instances of divorce, it is essential that the legal custodian of the child(ren) grant permission for the services. If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you may be asked to provide a copy of the court order which names you the legal custodian of the above children.
Are you willing to do so? Yes No
~If the answer to any of the above questions is "No," counseling services can not be provided to the above-named child(ren) until a copy of the court order which names you the legal custodian is provided to this office.

I acknowledge that both natural parents, even though divorced, may have a right to obtain from the provider named below information regarding the nature and course of treatment of the child(ren).

- Colorado State law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agency.
- This treatment may also include referral to other appropriate State and County agencies for further counseling.

I, ____________________________, consent to _________________________of *Journeys Counseling Group LLC* in providing psychological services to the child(ren) named above.

____
Signature of person authorizing consent /Date

____
Signature of Counselor /Date

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