



Mighty Oaks Counseling, PLLC
Family Enrichment and Play Therapy Center

Dr. Sarah E. Carlson, LPC-S, RPT, RYT

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CONSENT FOR TREATMENT OF A MINOR CHILD

We/I, _____, parent(s) and/or guardian(s) of the minor child(ren) _____, give Dr. Sarah E. Carlson, LPC-S, RPT, RYT full and unconditional authority to proceed with a clinical evaluation and treatment as her judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child(ren). We/I have the legal power to consent to psychological and mental health assessment and treatment of said minor child(ren). It is clearly understood that Dr. Sarah E. Carlson, LPC-S, RPT, RYT is hereby fully released from any claims and demands that might arise or be incident to the evaluation and/or treatment, provided that her duties are performed with standard care and responsibility to the best of her professional ability.

Printed Name(s)

Signature—Client/Parent

Date

Signature—Client/Parent

Date

Dr. Sarah E. Carlson, PhD, LPC-S, RPT, RYT

Date

In cases of separation or divorce: I have provided legal documentation (divorce decree or current court orders) regarding conservatorship and my legal right to consent to treatment for my child. _____(Parent Initial)