Karen Stone, MS, LMFT, LCDC

CONSENT FOR THE TREATMENT OF MINORS

Minor's Name _____

Date of Birth _____

This is to certify that I give permission to Karen Stone, MS, LMFT, LCDC to provide counseling or therapy for my minor child.

This treatment may include individual counseling, family counseling, and group counseling.

_____	_____
Signature of Parent/Guardian	Signature of Parent/Guardian
_____	_____
Printed Name of Parent/Guardian	Printed Name of Parent/Guardian
_____	_____
Street Address	Street Address (if different)
_____	_____
City/State/Zip Code	City/State/Zip Code (if different)
_____	_____
Phone	Phone
_____	_____
Date	Date