Anat Fein, MA, LMFT
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# CONSENT TO TREAT A MINOR

I, _____ hereby acknowledge that I am the parent/legal
Print name
guardian of the below named minor child, and do consent to the provisions of counseling services to the child with Anat Fein, MFT.

**If you are separated or divorced, please initial the appropriate choice below:**

- ¨ There *is no court order or agreement* that states both parents must give permission for this treatment.
- ¨ There *is a court order or agreement* and *both parents' signatures* are required.

(Please provide the court order ***before*** therapy begins).

Name of Minor Child_____

Parent or Legal Guardian's signature _____

Relationship to minor_____Date_____

Address _____ Phone number_____