

Erin M. Thomas, MA, LPC

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CONSENT FOR PSYCHOTHERAPY TREATMENT FOR A MINOR

to meet with my chi	ld/children(Min	nor's Name) ' (Minor's Name)
(Minor's Name)	(Minor's Name)	(Minor's Name)
for the purpose of pa	sychotherapeutic treatment.	
I certify that I have	the legal authority to give co	onsent for treatment.
Please check one:		
	married to the child's other not married to the child's or	r parent/guardian. hther parent/guardian and decision making
I am		
responsibilit	ies have not been established	d in court.
responsibilit	ve sole decision making for i	
responsibilit I hav verifying my	ve sole decision making for 1 v authority.	d in court. my child and can present therapist with paperwork
responsibilit I hav verifying my I hav	ye sole decision making for i v authority. ye joint decision making for	d in court.

Therapist Signature: _____

Date: