Leslie Caffey, MA, LPC
Licensed Professional Counselor (469) 994-1075

CONSENT FOR TREATMENT OF A MINOR

We/I the undersigned _____,
parent(s) and/or guardian(s) of a minor child
_____, give Leslie Caffey MA, LPC 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. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that Leslie Caffey MA, LPC 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.

Signed this _____ day of _____, 20_____

Mother or Guardian _____
Father or Guardian _____

The above explained to: (circle all that apply) Mother/Father/Guardian
By _____on the _____ day of _____, 20_____