CONSENT TO TREAT MINOR

Name of minor client: _____

Name of parent or guardian: _____

As the parent or legal guardian, I agree to allow _____to receive individual counseling from Sabrina Hickel, LPC, NCC.

I understand that as the parent or legal guardian of _____, I am entitled to access the medical file and the information discussed in the counseling sessions. I also understand that asking for that information may affect the therapeutic relationship between client and counselor.

_____	_____	_____
Parent or Guardian Signature	Date	Phone Number
_____	_____	_____
Counselor Signature	Date	Phone Number