CONSENT TO SERVICES OF MINORS

Please read the following statement before signing:

The initial visits at Family Counseling Service are considered *consultation and assessment* to determine the appropriateness of our services for your child.

In cases involving custody, we require that you provide *proof of legal custody*.

By signing below, you attest that you have the legal right (legal custody) regarding_____ (name of child/ date of birth) to seek mental health services for this child, and are not required to obtain permission from any other person.

A copy of divorce documents reflecting the above will be made available before final treatment recommendations can be made.

In the event that others with legal rights related to consent to services for the minor child(ren) (*named below) should contact the agency it is understood that FCS may confirm attendance and progress.

In the event the other party requests treatment records, the adult for which the initial consultation was provided will be notified and given an opportunity to seek legal remedies should there be a dispute as to rights related to access to specific treatment records.

*Other adults with legal rights related to consent to services.
Name_____

Contact Information (if known) _____

Signature of parent/legal guardian Date

Signature of witness receiving document of custody Date