

April Betty, LPC
2095 W. 6th Ave.
Suite # 212
Broomfield, CO 80020
(720) 235-8665

Consent for the Treatment of a Minor

I, _____, hereby authorize April Betty,
LPC to provide mental health services to

(child's name)

I attest that I am the sole/joint (please circle one) legal guardian of the above
stated child and am legally and financially responsible for the above stated
child. In the case of joint custody, both legal guardians are required to sign
this consent form before a minor child can be seen in therapy. **Legal
documentation of the custody/guardianship agreement is needed at the
time of signing this consent form and before the minor child is seen in
therapy, if applicable.**

***I further understand that if legal parenting decision making rights
change at any time my child is seen in therapy, it is my responsibility to
notify the therapist within 7 days.**

Signature of parent or legal guardian

Date

Signature of parent or legal guardian (for joint custody)

Date