Consent for Therapeutic Treatment/Counseling of a Minor

Name of Parent/Guardian: _____

Name of Minor: _____DOB: _____

Name of Therapist: Mary Anderson Schroeter, LCSW; License Type: LCSW # 09924338

This is to certify that I give Mary Anderson Schroeter, LCSW consent for the treatment of my child. This counseling may include several different therapeutic techniques such as CBT, DBT, Play Therapy, Splankna, EMDR, Sand Play Therapy, Family Therapy, or referrals for Psychological or Psychoeducational testing. This counseling may also include referrals to other appropriate state, county or professional agencies for further consultation, if necessary.

Signature of Parent/Guardian: _____

Date: _____

Printed Name: _____

Phone number: _____

Mary Anderson Schroeter, LCSW. Integrative Pathways Counseling, LLC, 7950 S Lincoln St., Suite 108, Littleton, CO 80122. www.integrativepathwayscounseling.com. (303) 883-7271