

Julie Hussman, M.A., LMFT  
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**CONSENT FOR TREATMENT OF A MINOR CHILD**

(The following statements provide your legal consent to and financial responsibility for counseling services to a minor child. These statements are important to protect the child, the parent/guardian/conservator, and the therapist. Please carefully review this information and sign where indicated. You are requested to discuss any question you may have with the therapist.)

**STATEMENT OF RESPONSIBILITY AND GRANT OF PERMISSION FOR THERAPY**

I am the : Natural/Biological Parent: [ ] Legal Guardian: [ ] Managing Conservator of [ ]

\_\_\_\_\_

(Name of minor child)

I am legally responsible for the child named above and grant permission to Julie Hussman, M.A, LMFT to conduct therapy with this child.

I accept responsibility for the timely payment of all fees due to Julie Hussman, LMFT for services provided to this child.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DUTY TO WARN NOTICE**

Julie Hussman M.A., LMFT, is committed to the confidentiality and privileged communication with all clients. There are, however, several exceptions. According to California law, any evidence of child abuse must be reported to the authorities. If any individual intends to take harmful, dangerous, or criminal action against another individual, or against himself/herself, it may be the therapist's duty to report such action or intent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_