

Gate Healing, PLLC
Jonathan F. Anderson, LPC-Supervisor
Professional Consulting, Psychotherapy & Supervision
(512) 771-7621
3939 Bee Cave Rd, Ste A-203
Austin, Texas 78746

Consent to Treat a Minor

I, _____, as the parent and/or legal guardian for the minor child, _____, give my consent for said child to receive counseling from Jonathan F. Anderson, MA, LPC. I understand that I may withdraw this consent at any time. I will first notify Jonathan F. Anderson, MA, LPC by telephone and then in writing, if and when I choose to withdraw this consent.

Parent/Guardian Information:

Child's Information:

Name:

Name:

Address:

Address:

City, State and Zip:

City, State and Zip:

Phone with area code:

Phone with area code:

If applicable, please check type of custody arrangements:

_____ Joint Custody

_____ Sole Custody

By signing below, I agree that the above information is accurate as noted.

Custodial Parent/Guardian Signature

Custodial Parent/Guardian Signature