Gate Healing, PLLC
Jonathan F. Anderson, LPC-Supervisor
Professional Consulting, Psychotherapy & Supervision
(512) 771-7621
3355 Bee Caves Rd, #505
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