

The
LIFEWORKS GROUP INC

Making Life Work for You

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CHILD AND ADOLESCENT CONSENT FOR TREATMENT

CLIENT: _____

Birth date:

(last name)

(first)

(middle)

I certify that I am the (circle one) father/ mother/ legal guardian of the above named child/ adolescent and that I do have legal custody of the above named child/ adolescent. I hereby give my authorization and consent for the above named child/ adolescent to receive assessment or therapy from a professional therapist of the LifeWorks Group.

Date: _____ Signature: _____

DIVORCE/LEGAL SEPARATION COLLECTION POLICY

It is our policy that the parent/ guardian bringing a child/ adolescent to our office for treatment is responsible for payment of services rendered at that time. If you have a financial arrangement for payment of the child's medical care, either oral or written, with the child's/ adolescent's other parent or responsible party, you will be expected to pay for the child's/ adolescent's care at the time of service and arrange for your personal reimbursement with the other party individually. In the event of a true emergency, treatment will not be denied to your child/ adolescent.

I have read, understood and agree to the above policy:

(Print client's name)

(Parent/Guardian Signature)

(Date)

(Witness)