

**RESOLUTIONS THERAPY
INDIVIDUAL, COUPLE & FAMILY THERAPY**

CONSENT TO TREATMENT A MINOR CHILD OR DEPENDENT

This is to certify that I /We, _____, have legal custody or guardianship of the following minor(s)/dependent(s) as well as legal right to authorize his / her / their care, treatment and/or council:

Name(s) of Minor(s) / Dependents(s):

Date of Birth:

- | | | |
|----|--|--|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

I give my consent for him / her / them to receive individual and/or family therapeutic services from the clinicians at Resolutions Individual, Couple & Family Therapy, LLC

Legal Custodial Parent / Guardian Signature	Date
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Legal Custodial Parent / Guardian Signature	Date
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Witness Signature	Date
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