



## Consent for Counseling of Minors

Name of Parent/Guardian: \_\_\_\_\_

Name of Minor: \_\_\_\_\_

Minor's date of Birth: \_\_\_\_\_

Name of Counselor: R. Scott Gornto

License type: LMFT

License # 5152, Texas LMFT

This is to certify that I give permission to Auxano Counseling for treatment of my child. This counseling may include individual or family psychotherapy, counseling and testing. This counseling may include consultations with other associates of this institution. This counseling may also include referrals to other appropriate state and county or professional agencies for further consultation if necessary.

Signature of Parent/Guardian: \_\_\_\_\_

Printed name of Parent/Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact (Other than yourself): \_\_\_\_\_

Their Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_