Laurie Nickel Supkoff, LCSW
1329 Howe Avenue, Suite 201
Sacramento, CA 95825
(916) 743-1605

Consent for Treatment of Minors

Minor's Name:______________________________________ DOB:_______________________

This is to certify that I give permission to Laurie Nickel Supkoff, LCSW, for treatment of my child/guardian. This treatment may include individual psychotherapy or family counseling.

This treatment may include consultations with other associates including Educational Psychologists, Psychiatrist, Career Counselors or Nutritionists.

California State law mandates the reporting of certain types of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse.

All actual or suspected acts of child abuse will be reported to the appropriate state and county agencies.

It is also a mandatory reporting issue if the child is found to be a harm to self or an identifiable other person/people.

All material discussed during individual psychotherapy or family counseling sessions is confidential and can be released only with the permission of the holder of the privilege which in most cases is the minor.

I have been informed of the limitation to confidentiality in the Office Policies form, which I have read and signed.

My relationship to the minor client (parent, grandparent, etc.): ___________________________

____ ______________________
Signature of Parent/Guardian Date

____ ______________________
Signature of Parent/Guardian Date

____
Print name of Parent/Guardian

____
Street Address

____
City Zip