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Consent to Treatment of a Child

Name of child client:

The therapist named below and I have discussed my child's situation. I have been informed of the risks and benefits of several different treatment choices. The treatment chosen includes these actions and methods:

Individual Therapy

Family Therapy

These actions and methods are for the purposes of:

Increasing awareness of and addressing underlying emotional difficulties

Identifying and addressing family dynamics in an effort to improve family communication and relationships

I have had the chance to discuss all of these issues, have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist permission to begin this treatment, as shown by my signature below.

Signature of parent/guardian

Date

I, the therapist, have discussed the issues above with the child's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

Signature of therapist

Date

Copy accepted by parent/guardian Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.