INTAKE REGISTRATION FORM - CONSENT FOR TREATMENT OF MINOR

Please print all information except signature

REGISTRATION INFORMATION for MINOR

LAST Name ______________________ **FIRST Name** _________________ **DOB** ______ **Age** _____

Address ______________________________________ **City** ____________________ **Zip** __________

School _____________________________ **Grade** _______ **Primary Teacher** _____________________

Name of Father: _________________________ **Name of Mother:** ____________________________

Father Home # (   ) _____________ **Work # (   )** _______________ **Cell: (   )** ______________

Mother Home # (   ) _____________ **Work # (   )** ________________ **Cell: (   )** ______________

Referred by ______________________________ **Relationship to You:** _________________________

CONSENT FOR TREATMENT OF MINOR

Patient Name ____ **(please print)**

Therapist

▢ **Barry C. Barmann, Ph.D.**
California Lic. # PSY10035
Nevada Lic. # PY0672

▢ **Mary B. Barmann, MFT**
Lic. # MFC21169

This is to certify that I give permission to the Therapist checked off to provide counseling and psychotherapy to my child. This treatment may include individual, family or group psychotherapy, testing, and consultations with Psychologists, Counselors, Physicians, or Teachers as stipulated in a signed and completed Release of Information form. California State Law mandates reporting of child abuse including physical and sexual abuse, unlawful sexual intercourse, neglect, emotional, and psychological abuse. Actual or suspected acts of child abuse will be reported to the appropriate agency and may include referral to other appropriate State and County agencies.

CONSENT TO CONTACT – Check off (✔) appropriate boxes

You may contact me (parent/guardian) with information about my child's treatment as follows:

FATHER: ▢ Home # ▢ Work # ▢ Cell ▢ Text ▢ Home Address ▢ Email: ________________________

MOTHER: ▢ Home # ▢ Work # ▢ Cell ▢ Text ▢ Home Address ▢ Email: ________________________

My written signature indicates that I have read & understood the policies of Behavior Therapy and Family Counseling Clinic & agree to abide by all policies. A copy of this document shall be as valid as the original

Signature of Parent/Guardian (mother) ____________________________________ **Date:** _________

Signature of Parent/Guardian (father) ____________________________________ **Date:** _________

Witness/Therapist ____ **Date** ______________________

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