WAVE Professional Clinical Counselors Inc.

WAVE THERAPY
3150 PIO PICO DR. SUITE 105
CARLSBAD, CA 92008

PHONE: (760) 500-3325

Parent/Guardian Consent for the Treatment of a Minor

I certify that I am the parent or guardian of the child who is seeking therapy services at WAVE Therapy. I give my permission for my child to participate in counseling/therapy at WAVE Therapy with the therapist, social worker, and/or therapist intern.

Because counseling is based on a trusting relationship between therapist and client, the therapist will keep information shared by the minor client confidential except in certain situations in which an ethical responsibility limits confidentiality. You will be notified under the following circumstances:

1. The client reveals information about hurting himself/herself or another person.
2. The client or another person may be in physical danger.

By signing this form, I give my informed consent for my child to participate in counseling/therapy. I understand that anything that my child shares will be kept confidential except in the above-mentioned cases or any other cases agreed upon between you and your therapist.

You may revoke this consent at any time. Please submit your revocation of consent to your therapist in writing.

Signature of Parent/Guardian	Date
Printed Name	Date of Birth
Full Name of the Minor Client	Date of Birth