Adriane Nada, MS, LMFT, LPCC
24632 San Juan Ave. #200, Dana Point, CA 92629
949-272-1692

CONSENT TO TREAT A MINOR

I/We _____, parent(s) or legal guardian(s)
parent(s) / guardian(s)

of _____, a minor, hereby consent to
(minor)

counseling services of said minor by Adriane Nada, MS, LMFT, LPCC. I understand that children are entitled to a confidential relationship with their therapist, and I will respect that confidentiality.

SIGNED: _____

PRINT NAME: _____

Relationship to minor: _____ (mother, father, legal guardian)

SIGNED: _____

PRINT NAME: _____

Relationship to minor: _____ (mother, father, legal guardian)