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Consent for Counseling of Minors

This is to certify that I give permission to Dora (Shawn) Williams LPC -Intern for my minor child to participate in therapeutic counseling treatment. I hereby affirm I have legal custody of my child. In the case of divorce or separation, I have made available for copy any and all legal documents regarding my minor child verifying the court's orders concerning my child's mental health.

Name of Parent/Guardian: _____

Name of Minor: _____

Minor's Date of Birth: _____

Signature of Parent/Guardian: _____ Date: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Emergency Contact (Other than yourself): _____

Phone: _____

Therapist: _____ Date: _____

Required Documentation: Yes _____ No _____

Explanation:
