

Joint Custody Consent Form

Eastlake Community Counseling

Jeff Palitz, MFT

Minor Client's Name: _____ Date: _____

1. Name of Parent Responsible for Making/Cancelling Appointments:

Name

2. Name of Parent Responsible for Transportation to/from Appointments:

Name

3. Name of Parent Responsible for Payment of Co-Payments and Fees:

Name

By signing below, I authorize and request that Jeff Palitz, MFT carry out psychological examinations, treatment and/or diagnostic procedures that now or during the course of my child's care as client are advisable. I also understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable and that the therapist can make no guarantees regarding treatment outcomes.

Further, I am consenting on behalf of a minor child, dependent or beneficiary to authorize Jeff Palitz, MFT to deliver mental health services to him/her. I understand that all policies stated in the welcome packet apply to the client. **I further accept that although my participation may be required as part of the client's treatment, the client's records are confidential, and by law I cannot access these records if Jeff Palitz, MFT believes such access would be detrimental to the patient.**

CONSENT TO TREATMENT SIGNATURE:

Father's Signature

Date

Mother's Signature

Date