

Consent to Treatment of a Minor

Name of Minor Client: _____

Client's Date of Birth: _____

The therapist named below and I have discussed my child's situation. I have been informed of the risks and benefits of treatment. The treatment chosen includes these actions and methods:

- Psychological Evaluation/Intake with Christina Kontos, LCSW
- Individual Psychotherapy from Christina Kontos, LCSW

These services are to be provided by the therapist named above, or by another professional as the therapist sees fit. The fees for these services will be \$150 for Psychological Intake and \$110 per session of Individual Psychotherapy.

Sessions will meet once or twice per week for approximately 50 minutes. If you need to cancel, please let me know 24 hours in advance. I understand that there are times when you may not know 24 hours in advance when you need to cancel, so I allow for 1 exception. After that, you will be charged a \$50 "no show" fee.

If you need to reach me during the day, you can leave a message at (713) 256-1538 or page me at (713) 415-9654 and I will return your call as soon as I can. If you are experiencing an emergency or crisis, please page me at (713) 415-9654 and indicate it is urgent. If you cannot reach me, or do not hear back from me right away, please call 911 or go to the nearest emergency room.

I have had the chance to discuss any questions and issues, have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist (or another professional, as he or she sees fit) permission to begin this treatment, as shown by my signature below.

My signature below means that I understand and agree with all of the points above.

Signature of parent/guardian

Date