ALYSON JONES
& ASSOCIATES

Parental Consent for Counselling

I _____ give consent for my child(ren) _____ to receive counselling with _____ at the office of Alyson Jones & Associates.

Children's Date of Birth: _____

Children's Address:

_____

_____

Home Phone: _____Cell Phone: _____ Work Phone: _____

By signing this consent I acknowledge that I understand that the therapist may consult with the Clinical Director regarding this case. The therapist may seek additional consultation and supervision on this case, but will protect the identity of the client during any external consultations.

My signature below confirms that I understand that any services provided by the therapist to my child(ren) will be done in the best interests of the child(ren). I understand that the therapist has a duty to report as outlined in the consent to counselling form.

I have read the above and had an opportunity to discuss this consent with the therapist and had any questions answered to my satisfaction.

_____ _____

Signature Signature

_____ _____

Date Date

Alyson Jones & Associates
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