Alliance Counseling and Education Center
1450 Keller Parkway, Suite 108-205
Keller, TX 76248

Phone: 800-947-7659 **www.AllianceParenting.com** **Fax: 940-539-9941**

CONSENT FOR TREATMENT OF A MINOR

We/I, the undersigned __________________________________, parent(s) and/or guardian(s) of a minor child ___________________________________, give Alliance Counseling and Education Center's therapist full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that Alliance Counseling and Education Center and its therapist are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that the therapist's duties are performed with standard care and responsibility to the best of your professional ability.

Signed this ____day of _________, 20__

____
Mother or Guardian

____
Father or Guardian

The above explained to: (circle all that apply) Mother / Father / Guardian

By __________________________________on the ____day of _________, 20__

AUTHORIZATION FOR TREATMENT OF MINOR

I understand that I am responsible for payment at the beginning of each scheduled appointment time. I also agree to be fully responsible for full payment of services unless other arrangements have been previously made in writing with Alliance Counseling and Education Center or an order has been put in place by the courts (only related to court ordered counseling). I understand that therapist at Alliance Counseling and Education Center do not bill insurance and it is my responsibility to research and file for out of network insurance benefits. (Court ordered counseling is typically not covered by most insurance companies). I understand that my therapist at Alliance Counseling and Education Center will provide a detailed receipt upon my request should I chose to submit for out of network insurance benefits.

______________________________ ______________________________

Parent/Guardian Date

______________________________ ______________________________

Parent/Guardian Date