L. Gordon Psychotherapy
2718 Telegraph Avenue , Suite 210
Berkeley, CA 94704
510-761-5609
MFT#50459

CONSENT TO TREAT MINOR

Child's Name:_____ Nickname:_____ Sex____ Age____
D.O.B.___/___/___ SS#:_____-____-_____

Child's primary address:_____
If no please provide alternative address:_____
Please list any medications prescribed for minor:
_____

Doctor _____ Last seen _____ Psychiatrist _____ Last seen _____
List any head injuries, past or present major illnesses or allergies:
_____

School_____ Grade ____ IEP or Special Education? _____ GPA

Father's Name: _____ SS#:____-____-____ DOB ___/___/___

Address:_____ Zip Code:_____ Phone _____
(OK to call Y/N)
Mother's Name: _____ SS#:____-____-____ DOB ___/___/___

Address:_____ Zip Code:_____ Phone _____
(OK to call Y/N)

Guardian Name: _____ SS#:____-____-____ DOB ___/___/___

Address:_____ Zip Code:_____ Phone _____
(OK to call Y/N)

In Case of Emergency Contact:
Name _____Relationship _____ Phone _____

Name _____Relationship _____ Phone _____

Please check all boxes that apply to minor and family:
__Divorce __Legal Separation __Custody __Guardianship __Restraining Orders __Current Litigation Issues __Probation

Any issues concerning Divorce, Custody, Guardianship, Probation and/or Restraining Orders will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records.

I, (print name) _____, am the mother/father/legal guardian (circle one) of _____, and I authorize Loretta Gordon, MFT to provide psychotherapy to said minor. I also agree to be legally responsible for any charges said minor may incur during therapy with Loretta Gordon, MFT. _____ (initial)

Signature: _____ Date:_____

Witness Signature: _____ Date_____