CONSENT FOR TREATMENT OF A MINOR
Fonda Hart, LMFT

I/we am/are the parent(s) or legal guardian(s) for ______________________________and have the authority to consent to counseling and/or Brainpaint Neurofeedback with The Office of Fonda Hart, LMFT. The signature(s) below grants authority to perform responsible assessment procedures and/or conduct treatment necessary for my child's welfare.

I understand that The Office of Fonda Hart, LMFT will attempt to guard the confidentiality of my child. I understand that there are limits to confidentiality which include: 1) Suspected child abuse or elder abuse; 2) Immediate danger of self-harm by my child; or 3) If my child is in imminent danger of harming someone else. I understand that Brainpaint Providers are also mandated reporters, which means that, if she has reasonable suspicion that any of these dangers exist, she will be required to notify law enforcement and/or Child Protection Services, as a mandated provider.

____
Printed Name of Parent/Guardian

X__________________________________ ______________
Signature of Parent/Guardian Date

____
Printed Name of Parent/Guardian

X__________________________________ ______________
Signature of Parent/Guardian Date

The office of
Fonda Hart, LMFT
6042 N. Fresno Street, Suite 101, Fresno, CA 93710
(559) 801-1430 • www.fresnocounseling.com