auxano
counseling

Consent for Counseling of Minors

Name of Parent/Guardian: _____

Name of Parent/Guardian: _____

Name of Minor: _____

Minor's date of Birth: _____

Name of Counselor: R. Scott Gornto
License type: LMFT
License # 5152, Texas LMFT

This is to certify that I give permission to *Auxano Counseling* for treatment of my child. This counseling may include individual or family psychotherapy, counseling and testing. This counseling may include consultations with other associates of this institution. This counseling may also include referrals to other appropriate state and county or professional agencies for further consultation if necessary.

Signature of Parent/Guardian: _____

Printed name of Parent/Guardian: _____

Street Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Signature of Parent/Guardian: _____

Printed name of Parent/Guardian: _____

Street Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact (Other than yourself): _____

Their Home Phone: _____ Cell Phone: _____