CONSENT FOR TREATMENT OF MINORS

Name: _____

Date of Birth : _____

Therapist and/

or staff: _____

- This is to certify that I give permission to No Limit Health and Education, Inc. and the Therapist(s) listed above for the treatment of my child.
- This treatment may include individual or group psychotherapy, counseling, coaching, psychosocial rehabilitation, case management, and/or testing.
- This treatment may include consult Associates including Psychologists, LMHC/MFT/LCSW Interns, Emotions Coaches, Graduate Interns, Career Counselors and/or Nutritionists.
- This treatment may also include referral to other appropriate State and County agencies for further counseling and/or services
- Florida State law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional psychological abuse.
- All actual or suspected acts of child abuse will need to be reported to the appropriate agency.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Printed Name of Parent/Guardian Date

_____

Street Address City State Zip Code

_____

Phone Number