PAHRUMP VALLEY COUNSELING

Ramona Sanchez, LCSW, LMFT
David VanDerBeek, LMFT
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Child & Adolescent Consent to Treat

I, _____, authorize Ramona Sanchez, LCSW, LMFT and/or David VanDerBeek, LMFT to provide Mental Health Services to myself and/or minor child _____.

I understand that my child will receive a diagnostic interview with a professional therapist to determine the type(s) of service(s) my child would best benefit from. In addition, by signing below, I acknowledge that I have a right to select a qualified provider of my choosing.

_____

Print Parent/Legal Guardian Name

_____ _____

Signature Date

_____ _____

Ramona Sanchez, LCSW, LMFT/David VanDerBeek, LMFT Date