Maura Loftus
LCSW

232 West Main Street, Suite 103
Tustin, CA 92780

CONSENT TO TREAT A MINOR

Minor's Name: _____

Minor's D.O.B: _____/_____/_____

Minor's Social Security Number: _____

Minor's Address: _____

Minor's Phone Number: (____) _____-_____

Father's Name: _____

Father's D.O.B:_____/_____/_____

Father's Social Security Number: _____

Father's Address: _____

Father's Phone Number: (____) _____-_____

Mother's Name: _____

Mother's D.O.B: _____/_____/_____

Mother's Social Security Number: _____

Mother's Address: _____

Mother's Phone Number: (____) _____-_____

Minor's Mental/Behavioral Health Insurance Company: _____

Subscriber/Responsible Party: _____

Who has physical custody? _____

Who has legal custody? _____

I/WE UNDERSTAND THAT ALL POLICIES AND DISCLOSURE NOTED IN THE *NOTICE OF PRIVACY PRACTICES & MENTAL HEALTH DISCLOSURE FORM* APPLY TO THE MINOR THAT I/WE REPRESENT. I/WE ARE THE LEGAL GUARDIANS OR LEGAL REPRESENTATIVES OF THE MINOR AND ON THE MINOR'S BEHALF LEGALLY AUTHORIZE MAURA LOFTUS, LCSW TO DELIVER MENTAL HEALTH SERVICES TO THE MINOR.

Name: _____

Signature: _____

Date: _____/_____/_____