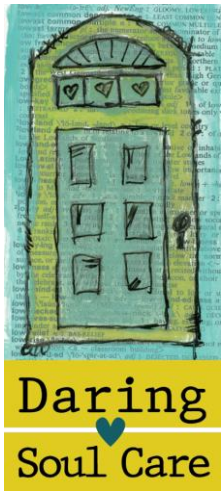

7890 St. Andrews Circle
Orlando, FL 32819
(407) 342-3559
debbie@
daringsoulcare.com

CONSENT TO TREAT MINOR

Name of Minor to be Treated:

_____
(Child's Full Name)

I agree to avail the above-named minor child to the professional services of:

☐ **Debbie Miller, M.A., LMHC** LICENSED MENTAL HEALTH COUNSELOR #9860 or

☐ _____,

who is a Licensed Mental Health Counselor, Registered Mental Health Counselor Intern (under supervision, as specified by law) or a student intern completing a practicum (under clinical supervision of licensed professionals from their graduate education program). I consent accordingly to the minor child being seen in individual or group psychotherapy.

Name of Parent or Legal Guardian:

_____
(Please Print Full Name)

Signed: _____ Date:_____

Witnessed: _____ Date: _____

awake
●
brave
●
connected