Susan Ward, MA, LMFT, CMHS
Child, Couple, and Family Therapist
1900 Dock Place, Suite 7
Seattle, Washington 98107
Licensed Counselor #LF00002670

Agreement for Therapy Services with a Minor

I,____________________________________, attest that I am the parent/legal guardian of ______________________________

_______, and give my permission for this minor to receive services from Susan Ward, MA, LMFT, CMHS. Treatment may include individual and family therapy. Exclusions to the treatment are as follows:

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My goals for this treatment are as follows:

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These services are to be provided by Susan Ward, MA, LMFT, CMHS and may include confidential supervision and/or consultation in an effort to provide more appropriate services. Fees for treatment are payable at the time of service and are as follows:

- ❑ *50-minute session* *$100.00*
- ❑ *75-minute session* *$150.00*

I understand that information concerning my child/minor, is protected by strict confidentiality laws and requires my written consent prior to any disclosures. I also recognize that information regarding diagnosis and treatment approach is available to me at any time.

My signature below means that I understand and agree with all of the points above and acknowledge that this document does not supercede information provided to me in the Disclosure Statement.

________________________ ________________________
Signature of Parent/Guardian Date

________________________ ________________________
Susan Ward, MA, LMFT, CMHS Date