JOAN

KRIMSTON LCSW

PSYCHOTHERAPY

CONSENT FOR TREATMENT OF MINORS

CONSENT FOR TREATMENT

I, ____, authorize and request that Joan Krimston, L.C .S.W.provide the therapy for my child, ____ , which is now or duringthe course of his/her care as a client may become advisable. This process may include my child,me and other family members. I understand that I have the right to withdraw my child fromtreatment at any time. CONFIDENTIALITYI understand that any information revealed during the course of treatment regarding suspected-child abuse or neglect must be reported by the therapist to the appropriate authori-ties as requiredby law and may be done without my knowledge or consent.Please discuss any questions regarding the foregoing with Joan.

I have read and fully understand and accept and agree to the above terms and conditions.

______________________	______________________	__________
Client (print name)	Signature	Date

______________________	______________________	__________
Witness (print name)	Signature	Date

I

______________________ ______________________ __________

______________________ ______________________ __________

JOAN KRIMSTON, L.C.S.W.
11712 MOORPARK STREET, SUITE 102
STUDIO CITY, CA 91604
818) 319-7006
joankrimstonlcsw@gmail.com
www.joankrimston.com