Kathy Leary-Wilde, MA, LMFT
Licensed Marriage and Family Therapist, 47685

Consent for Treatment

I hereby authorize Kathy Leary-Wilde, MFT to carry out psychological examinations, diagnostic procedures and/or treatment, which now or during the course of my care as a patient are advisable.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement.

I have read and fully understand this Therapeutic Contract/Informed Consent of Treatment.

Client Signature _____Date____/____/____

Client Signature _____Date ____/____/____

Therapist Signature _____Date ____/____/____

I authorize treatment for the minor child(ren) under my care.

Name of child_____

Name of child_____

Parent/Guardian Signature _____

Date ____/____/____

Parent/Guardian Signature _____

Date ____/____/____