Kyle Jankowski, M. MFT, LMFT

500 N 1604 E. #220 San Antonio, TX 78232

Independent Contract Therapist

INSTITUTE FOR COUPLE AND FAMILY ENHANCEMENT

Consent for Treatment of Minors

Parent/Guardian Name(s): ______________________________________

This is to certify that I give my permission to Kyle Jankowski, LMFT for treatment of my child(ren). My/our signatures below affirms that I have the legal authority to consent for treatment of the child(ren) named below. If my legal guardianship is in any way directed by a court order, I agree to provide a copy to Kyle Jankowski, LMFT for his records. I agree to inform Kyle Jankowski, LMFT of custody and guardianship arrangements, and, if applicable, will inform the co-parent of the child(ren)'s participation in therapy.

I/we, the legal parent(s) or guardian(s) of the minor child(ren):

Child's Name: __________________________ **Child's Date of Birth:**__________________

Child's Name: __________________________ **Child's Date of Birth:**__________________

Child's Name: __________________________ **Child's Date of Birth:**__________________

grant my/our permission for any psychotherapy, testing, or diagnostic evaluation that **Kyle Jankowski, LMFT** may deem necessary in individual or family psychotherapy. I/we understand the potential for emotional discomfort and relationship changes not originally intended. I/we understand **Kyle Jankowski, LMFT** does not guarantee any particular results or outcome from the psychotherapy process.

Parent/Guardian Initials ___________

understand and agree to the ICFE's confidentiality policies as detailed in the full consent form. These include the exceptions to confidentiality mandated by state law. These also include the possibility of sharing information disclosed in individual sessions, phone conversations, or written messages with those family members who have consented to treatment information.

Parent/Guardian Initials ___________

understand the risks of psychotherapy as explained in the full consent form. I/we understand **Kyle Jankowski, LMFT** does not provide emergency services and in the event of an emergency I/we agree to go to the nearest emergency room, call 9-1-1, or contact the Crisis Stabilization Unit of the Center for Health Care Services at 225-5481 (after hours 531-7826) or the United Way Help Hotline at 227-4357 (HELP).

Parent/Guardian Initials ___________

Kyle Jankowski, M. MFT, LMFT
500 N 1604 E. #220 San Antonio, TX 78232
Independent Contract Therapist
INSTITUTE FOR COUPLE AND FAMILY ENHANCEMENT

Consent for Treatment of Minors

To be signed by a legal parent(s) or guardian(s):

______________________________	___________________________	____________
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date

______________________________	___________________________	____________
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date

______________________________	___________________________
Kyle Jankowski, LMFT	Date