

**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 Susanna Kitayama, MS, LMFT-Associate 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 Mrs. Kitayama for her records. I agree to inform Mrs. Kitayama 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 Mrs. Kitayama 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 Mrs. Kitayama 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 that Mrs. Kitayama 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 \_\_\_\_\_

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

\_\_\_\_\_  
Susanna Kitayama, MS, LMFT- Associate                      Date