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 Valerie B. Ryse, MS, LMFT-Associate for treatment of my child(ren). My/our signature(s) 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 Valerie Ryse for her records. I agree to inform Valerie Ryse 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: ___________

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Grant my/our permission for any psychotherapy, testing, or diagnostic evaluation that Valerie Ryse 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 Valerie Ryse 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 to individual sessions, phone conversations, or written messages with those family members who have consented to treatment information. This also includes that Valerie Ryse, MS., LMFT-Associate is under the clinical supervision of Jason Northrup, Ph.D., LMFT-S as detailed in the Informed Consent form. I/we know that Dr. Northrup may be contacted directly at (210) 833-4011 or northrup@icfetx.com.

Parent/Guardian Initials: ________

Understand the risks of psychotherapy as explained in the full consent form. I/we understand that Valerie Ryse 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 1-800-316-9241 or 210-223-SAFE (7223).

Parent/Guardian Initials: ________

__________________________ __________________________ ______________

Printed Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

__________________________ __________________________ ______________

Printed Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

__________________________ ______________

Valerie B. Ryse, MS, LMFT-Associate **Date**