

# Hunter Counseling

*Caring and Confidential*

## CONSENT FOR PSYCHOLOGICAL AND COUNSELING SERVICES (CHILD)

### CLIENT INFORMATION

Child's Name:

Date of Birth:

Address:

Phone:

I, \_\_\_\_\_ consent for my child:  
Parent/Guardian Name

\_\_\_\_\_  
Child's Name

to receive psychological and counseling services from Hunter Counseling, LLC. All information pertaining to psychological and counseling services are confidential; however, administrative staff will participate in filing billing information. Administrative staff are held to confidential guidelines.

Services may include any of the following:

- a) Clinical Interview
- b) Psychological Testing
- c) Counseling
- d) Review of mental health, medical, psychiatric, legal, and school records
- e) Consultation with school staff, attorneys, other mental health professionals
- f) Interpretation and review of results
- g) Participation in behavior planning, PCP's, IEP's, and 504 plans as necessary
- h) Assisting with coordination of services as necessary

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date