Pauline Jarakian LMFT

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 CONSENT TO TREAT MINORS

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GIVE PERSMISSION FOR PAULINE JARAKIAN LMFT,

TO PROVIDE CHILD PSYCHOTHERAPY SERVICES TO MY

CHILD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WHOM IS A MINOR.

I UNDERSTAND THAT WHILE MOST OF THE THERAPY IS CONFIDENTIAL , PAULINE JARAKIAN WILL USE HER BEST CLINICAL JUDGEMENT AND BEST INTEREST OF MY CHILD IN SPEAKING WITH PARENTS REGARDING THE THERAPY SESSIONS AND WILL PROVIDE ASSESSMENT IMPRESSIONS AS NEEDED TO KEEP ME INVOLVED WITH MY CHILD’S MENTAL HEALTH PROGRESS.

THERE MAY ALSO BE TIMES WHEN IT IS BEST TO INVITE A PARENT OR PARENTS TO BE A PART OF THE THERAPY. PAULINE WIL EXPLAIN THE RATIONALE SHALL THIS OCCUR.

THE CHILD THERAPY INCLUDES TALK THERAPY, EXPRESSIVE ARTS, SAND TRAY AND PLAY THERAPY

TODAY’S DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT:CHILD’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILD’S BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_