Wilson Counseling
LIFE CAN BE GOOD

JOINT CUSTODY PERMISSION TO TREAT

I, AS JOINT CUSTODIAL PARENT OF _____, HEREBY GIVE PERMISSION FOR THE ABOVE-NAMED CHILD TO RECEIVE AND PARTICIPATE IN COUNSELING/MENTAL HEALTH SERVICES WITH WILSON COUNSELING, LLC. I UNDERSTAND THAT REQUIREMENT OF CONSENT FROM BOTH CUSTODIAL PARENTS IS REQUIRED FOR TREATMENT SERVICES TO BE PROVIDED. I UNDERSTAND THAT BOTH CUSTODIAL PARENTS WILL BE PROVIDED OPPORTUNITY TO PARTICIPATE IN TREATMENT PLANNING AND, WHEN APPROPRIATE AND RECOMMENDED BY THE TREATING CLINICIAN, PARTICIPATE IN THERAPY SESSIONS. I FURTHER UNDERSTAND THAT WILSON COUNSELING SHALL PURSUE PAYMENT OF AMOUNTS DUE FROM BOTH PARENTS AND THAT PERCENTAGES ASSIGNED BY THE COURT ARE NOT THE OBLIGATION OF WILSON COUNSELING TO DIVIDE.

_____
CUSTODIAL PARENT SIGNATURE

DATE: _____

Voice 270-904-1072 Fax 270-904-1073

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Bowling Green, KY 42104

252 N. Main Street
Russellville, KY 42276

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