

**Anchorpoint Counseling, LLC**

Verena Burger Schmid, LPC, CACII; 831 Royal Gorge Blvd #228, Cañon City, CO 81212; 719-248-8093

*PERMISSION TO TREAT A MINOR*

**Client Full Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**The above named client is in the physical custody of:**

\_\_\_\_\_  
Name of Person(s) or Institution

\_\_\_\_\_  
Address of Person(s) or Institution

I, (Printed Name of Parent/Legal Guardian/Conservator) \_\_\_\_\_

\_\_\_\_\_ give my explicit permission to **Verena Burger Schmid, LPC, CACII** to provide behavioral health counseling and/or addiction counseling to my child. Treatment may include individual, family or group psychotherapy and counseling, assessment and referrals to other appropriate State and County or professional agencies for further counseling. It may include consultation with other treatment providers already involved with your child’s treatment provided that you sign a release. Lastly, it may include referrals to self-help groups out in the community to augment counseling in the office.

**INFORMED CONSENT**

I understand that information that I or my child share in psychotherapy may be subpoenaed and considered in custodial issues. I further understand that my child/adolescent may be seen for individual and/or family therapy and that I and other family members may be involved in the family therapy process. I am aware that psychotherapy is not an exact science, and that no guarantees have been made regarding the results of treatment.

\_\_\_\_\_  
**Signature of Parent, Legal Guardian, or Conservator** **Date:** \_\_\_\_\_

\_\_\_\_\_  
**Street Address**

\_\_\_\_\_  
**City/State/ZIP**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Date:** \_\_\_\_\_

**Verena Burger Schmid, LPC, CACII**

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Revised 9/15 VBS