



Raduca Kaplan
(818) 809-7017
12355 Moorpark Street
Studio City, CA 91604

CONSENT TO TREAT MINOR

Child's Name: _____ Nickname: _____ Sex: _____ Age: _____
D.O.B.: ____/____/____ SS#: _____ - _____ - _____
Child's primary address: _____

If none, please provide alternate address: _____

Please list any medications prescribed for minor: _____

Doctor: _____ Last seen: ____/____/____
Psychiatrist: _____ Last Seen: ____/____/____

List any head injuries, past or present major illnesses or allergies: _____

School: _____ Grade: ____ IEP or Special Ed? Y / N GPA: ____
Father's Name: _____ D.O.B.: ____/____/____ SS#: ____-____-____
Address: _____ Zip Code: _____ Phone: (____) _____
Mother's Name: _____ D.O.B.: ____/____/____ SS#: ____-____-____
Address: _____ Zip Code: _____ Phone: (____) _____
Guardian's Name: _____ D.O.B.: ____/____/____ SS#: ____-____-____
Address: _____ Zip Code: _____ Phone: (____) _____

In Case of Emergency Contact:

Name: _____ Relationship: _____ Phone: (____) _____
Name: _____ Relationship: _____ Phone: (____) _____

Please check all boxes that apply to minor and family:

____ Divorce ____ Legal Separation ____ Custody ____ Guardianship
____ Restraining Orders ____ Current Litigation Issues ____ Probation

Any issues concerning Divorce, Custody, Guardianship, Restraining Orders and/or Probation will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records.

I, (print name) _____, am the (circle one) mother/father/legal guardian of _____, and I authorize Raduca Kaplan, LMFT, to provide psychotherapy to said minor. I also agree to be legally responsible for any changes said minor might incur during therapy with Raduca Kaplan, LMFT.

____ (Initial)
Signature: _____ Date ____/____/____
Witness Signature: _____ Date ____/____/____