Raduca Kaplan
(562) 477-7531
4201 Shadyglade Avenue
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 _____/_____/_____