Wes Imayanagita, LCSW

Consent for Treatment of Minors

Child's name:_____

DOB:_____

This is to certify that I have given permission to Wes Imayanagita, LCSW, for treatment of my child. This treatment may include individual, family or group psychotherapy. Psychological testing and assessment may also be a necessary part of treatment.

There will be occasions where I will consult with other professionals including teachers, educational psychologists, guidance counselors, physicians or psychiatrists.

I understand that California state law mandates the reporting of child abuse including, physical, sexual, unlawful sexual intercourse, neglect, emotional and psychological abuse.

_____ _____

Signature of parent/guardian Date

_____

Printed name of parent/guardian

_____

Address

_____ _____

Signature of parent/guardian Date

_____

Printed name of parent/guardian

_____

Address