Airmid Wellness
AND COUNSELING CENTER
1260 Old York Rd. Warminster, PA *office 215-293-0744* *fax 215-293-0745*

CONSENT FOR TREATMENT OF A MINOR

I, _____ (Parent or Guardian of):

Name of Child: _____

Child Resides at: _____

_____

Date of Birth: _____

Do consent and allow Therapist Name:_____

To treat my child in individual and family sessions as deemed necessary according to the individual therapist.

Parent Signature: _____

Parent's Address _____

_____

Parent's Phone #: _____ _____

Insurance Name_____

Insurance #_____

Name of Primary Card Holder: _____

Date of Birth of Primary Card Holder: _____