Ascent Counseling Services

717 South Boulevard, Suite 9, Baraboo, WI 53913

PERMISSION TO TREAT

I hereby grant my permission to _____

name of clinician

of Ascent Counseling Services to provide psychotherapeutic treatment to my child/protectee.

_____ _____

client name *date of birth*

I have been informed of this client's rights and understand that as the guardian of the child/protectee, I have the right to be informed and involved in the development of the treatment plan recommended for this individual.

_____ _____

parent/guardian signature *date*

_____ _____

witness *date*