Hope Renewed Counseling Services LLC

6000 Gisholt Drive Suite 202
Monona WI 53713

PERMISSION TO TREAT

I hereby grant my permission to ________________________________
Name of Therapist

of Hope Renewed Counseling Services LLC to provide

psychotherapeutic treatment to my child/protectee.

____ _____________
Name of Child Date

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.

____ _____________
Print name Date

____
Signature of Parent or Guardian

____ _____________
Witness Date