# Living Well Counseling Services, LLC

**4915 Monona Drive, #305, Madison, WI 53716**


## PERMISSION TO TREAT

I hereby grant my permission to ________________________________________of
(name of clinician)

Living Well Counseling Services, LLC to provide psychotherapeutic treatment to my child/protectee.
(circle one)

______________________________________________________________________
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