

BATSHEVA GRUBER-NASS LMFT

HOLISTIC PSYCHOTHERAPY AND NUTRITION

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CONSENT FOR TREATMENT OF MINORS

PARENT'S NAME: _____

CHILD'S NAME: _____

CHILD'S AGE: _____ CHILD'S DATE OF BIRTH: _____

I (We), as the parent(s) or legal guardian(s) of _____, a minor, the

Age of _____ years, do hereby consent, authorize, and request Batsheva Gruber-Nass, LMFT to

Administer such treatment deemed advisable, necessary, or requested for the above minor.

I (We) agree to hold Batsheva Gruber-Nass LMFT harmless and free from any claims, suits for damages, or complications which may result from such treatment.

SIGNATURE (PARENT OR GUARDIAN) _____

SIGNATURE (PARENT OR GUARDIAN) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____