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Consent to Treat Minor

I, _____
(The parent (s) / legal guardian – please print name)

give permission to: Deborah Rippee, M.A., LMFT (License #LMFT104043)
to provide psychotherapy for my child(ren) listed below:

It is without pressure or coercion that I sign this consent.

Signature: _____ Date: _____
(parent / legal guardian)

Signature: _____ Date: _____
(parent / legal guardian)

Witness: _____ Date: _____
Deborah Rippee, M.A., LMFT

This is effective for one year after the date of signing unless stipulated below:

Effective Date: _____ **End Date:** _____