SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

NAME: ____________________

DOB: ____________ **ID #:** ____________

Permission For School Based Services

I give permission for my child, ______________________________ **CLIENT NAME**, to be in treatment with Southwest Family Guidance Center and Institute (SWFGC). I understand that this treatment may be done at the office of SWFGC and/or at my child's school site: ____________________ **SCHOOL NAME.**

By requesting school-based therapy, I agree to initiate monthly contact with my child's therapist and understand that if I am requested by the therapist to meet or return phone calls it is my responsibility to follow through with my child's therapist's request. If I am unable to follow through with the therapist's requests, my child may be discharged from therapy services. I understand that my participation in my child's therapy is crucial to the improvement of my child's well-being.

I understand that any co-pays or other charges related to the services provided are due and payable to SWFGC.

GUARDIAN'S PRINTED NAME **RELATION**

GUARDIAN'S SIGNATURE **DATE**

THERAPIST'S PRINTED NAME (W/ CREDENTIALS) **DATE**