STACEY B. SHAPIRO, LCSW, LLC

CONSENT FOR TREATMENT

I hereby consent for my son/daughter _____ to receive psychotherapy from Stacey B. Shapiro, LCSW.

I recognize the crucial role of confidentiality in the client/therapist relationship, and I agree to honor the psychotherapist's maintenance of professional silence in support of that relationship.

I further understand that the psychotherapist will use his/her discretion in conveying to me any information that may come from these therapy sessions.

_____ _____

Client Signature (if age 14 & up) Date

_____ _____

Parent's Signature Date

_____ _____

Clinician's Signature Date