



## Bee Cave Therapy

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Mariellen McLean-Flores M.S., LPC

### Parental Consent for Minor

I, \_\_\_\_\_, give permission for my child,  
\_\_\_\_\_, to be treated by Mariellen  
McLean-Flores, M.S., LPC for the purposes of counseling. I also understand  
that in order for therapy to be successful with any individual, their  
confidentiality needs to be respected, even in the case of a minor child, with  
exceptions considering the minor is a danger to him/herself or to others.  
I understand that his permission to treat with respect for my child's  
confidentiality is given with my full consent. this consent will be valid  
throughout the duration of therapy, or until the following date:\_\_\_\_\_.

Parent's signature

Relationship

Date

\_\_\_\_\_