



COUNSELING & PSYCHOLOGICAL SERVICES
JOHN WOODEN CENTER WEST
221 WESTWOOD PLAZA
BOX 951556
LOS ANGELES, CALIFORNIA 90095-1556
(310) 825-0768

CONSENT FOR EVALUATION/TREATMENT OF A MINOR

Client's Name: _____
Last Name First name Middle Initial

ID#: _____

I understand that UCLA Counseling and Psychological Services (CAPS) is a professional agency offering a wide range of psychological and psychiatric evaluation and treatment. The service also includes graduate student training and psychological research. I understand that professional services are provided by psychologists, psychiatrists, social workers and graduate trainees. In all cases, interning therapists are supervised by a licensed mental health professional.

I understand that all information disclosed within sessions is confidential and may not be revealed to anyone outside the clinic without my permission except where disclosure is required or allowed by law (e.g. where there is a reasonable suspicion of abuse of children or elderly persons; where the client presents a serious danger of violence to another; where the client is likely to harm himself or herself unless protective measures are taken, or where a valid court order has been issued).

I further understand that the delivery of services, and the determination for the specific types and parameters of services to be delivered, is to be based solely upon the assessment, recommendation, and professional judgment of the CAPS staff.

If the decision is made by CAPS to recommend a particular type and course of treatment, I understand that I retain the right to agree to or to refuse such a treatment recommendation.

In the event that it is decided that CAPS is not the appropriate agency to meet my needs, or in the event that I do not agree to the treatment plan recommended, I understand that I will be given referrals to resources more appropriate to my therapeutic needs and goals.

Client Signature Date

Parent/Guardian's Signature Date