PARENT OR GUARDIAN CONTRACT

I understand that while my son/daughter: _____ is attending therapy with Ruth Lynch, LMFT, confidentiality will be respected. I also understand that only under emergency circumstances will specific information be shared with me.

I understand that fees for psychotherapy are due and payable at each session, unless prior arrangements have been made.

Name of minor (Client): _____

Parent/Legal Guardian: _____

Signature: _____ Date: _____

RUTH LYNCH, LMFT · **LIC #:** MFC47327 · **E:** RuthLynch211@gmail.com · **P:** (714) 584 - 4119