Consent for Treatment of a Minor

I/we do hereby give permission to have my/our minor child, _____participate in mental health treatment provided by Center for Family Guidance. When sessions occur, my/our child may talk, draw pictures, play games, or do other things to help his or her clinician(s) get to know my/our child better and understand his/her problems.

I/we understand that as parents we have a right to know about how our child is doing in treatment. Sessions or brief consultations by phone with us may be arranged so that we can talk about concerns I/we may have about my/our child. Sometimes communications will be arranged without my/our child and at other times the family may meet together.

The things my/our child discusses in sessions with his or her clinician(s) are private. The clinician(s) providing care will not tell others about the specific things told to him or her. The clinician(s) will not repeat these things to parents, teachers, the police, probation officers, or agency employees. There are exceptions to that confidentiality. First, as required by law, your child's clinician(s) will tell others what has been said if my/our child talks about seriously hurting him or herself or someone else. The clinician(s) have an obligation to tell someone who can protect my/our child or the person that my/our child has spoken of hurting. Second, if your child's clinician(s) have reasonable suspicion that my/our child is being seriously hurt or abused by anyone, the clinician(s) have a legal obligation to tell someone for my/our child's protection. I/we can also request information obtained in treatment be provided to others by completing a Release of Information form.

I/we are aware that we may stop treatment with Center for Family Guidance at any time. The only thing I/we will still be responsible for is paying for the services that have already been provided, as well as any other fees associated with treatment at Center for Family Guidance. I/we understand that we may lose other services or may have to deal with other problems if we stop treatment. (For example, if treatment has been court-ordered, I/we will have to answer to the court.)

I/we are aware that an agent of our insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments we receive. We understand that if payment for the services we receive here is not made, Center for Family Guidance may stop providing treatment.

Our signatures below show that we understand and agree with all of these statements.

_____ _____

Signature of parent (or legal guardian) Date Signature of parent (or legal guardian) Date

_____ _____

Printed name Relationship to client Printed name Relationship to client

_____

Signature of patient Date

_____

Printed name of patient

I, the treating clinician, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that the individuals completing this form person are not fully competent to give informed and willing consent.

_____

Signature of clinician Date